SURYA PSYCHIATRIC CLINIC

PATIENT REGISTRATION FORM

Today's date:	Provider:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Pharmacy Name:
Pharmacy Address: Pharmacy Phone and Fax #:

To protect your privacy, please indicate how you would prefer to be contacted. (Please choose all that apply):

- ○ Call and leave a phone message with detailed health information
- ○ Call and leave a message with a call back number

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Aetna ❑ United ❑ Cigna ❑ Health Net Insurances

❑ Medicare ❑ Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

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IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

I authorize Surya Psychiatric Clinic, PLLC to contact the above person/s in case of emergency.

Patient/Guardian signature *Date*

AUTHORIZATION

I authorize use of this form on all my insurance claim submission.
I authorize the release of any medical, mental illness, substance abuse, or other information necessary to process my insurance claims.
I understand that **I am responsible** for my bill, even in the event that services are not authorized by my insurance company.
I authorize **Tejaskumar B. Patel, MD** to act as my agent in helping obtain payment from my insurance carrier/s.
I irrevocably authorize payment of medical benefits directly to **Tejaskumar B. Patel, MD**. For services rendered to me.
I request payment of government benefits be made directly to **Tejaskumar B. Patel, MD**., who hereby accepts such assignment.
I permit a copy or fax of this authorization to be used in place of the original.
I also acknowledge that assignment of benefits to CarePlus does not relieve me of the responsibility of payment for disallowed services, co-payments, and deductibles associated with the provided services to the extent allowable by law.

Print Name

Patient/Guardian signature *Date*