

REGISTRATION FORM

(Please Print)



Vishal Chaurasia MD, founder

Pharmacy Name/Number:	PCP:
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PATIENT INFORMATION

Patient's Last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:	Apt. #	Social Security no.:			
Home phone no.: ()	Work phone no.: ()	Cell phone no.: ()	Email address		
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone no.: ()			
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other	<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital		
Other family members seen here:					

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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Employer:	Employer address:	Employer phone no.: ()			
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance <input type="checkbox"/> HealthNet <input type="checkbox"/> Arizona Foundation <input type="checkbox"/> Great West <input type="checkbox"/> Pacificare PPO <input type="checkbox"/> Secure Horizons <input type="checkbox"/> Other	<input type="checkbox"/> Medicare <input type="checkbox"/> BCBS <input type="checkbox"/> Aetna <input type="checkbox"/> UHC <input type="checkbox"/> Cigna <input type="checkbox"/> Lifewise				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MyDoctor LLC or insurance company to release any information required to process my claims.

Signature:

Date: