SHARAD VYAS , MD

PATIENT REGISTRATION

PATIENT'S NAME DATE:

LAST FIRST MIDDLE

DATE OF BIRTH: AGE GENDER M F PT SS#:

ADDRESS: CITY, ST, ZIP

HOME PHONE: PATIENT'S CELL

EMAIL ADDRESS: RACE: ETHINICITY: LANGUAGE:

FATHER'S NAME CELL PHONE

DOB: SS#: EMPLOYER: WORK #

MOTHER'S NAME CELL PHONE

DOB: SS# : EMPLOYER: WORK #

GUARDIAN CELL PHONE

(IF APPLICABLE) SS#

EMERGENCY CONTACT: ADDRESS:

(OTHER THAN PARENT) PHONE:

CLOSEST RELATIVE: ADDRESS:

(NOT AT YOUR ADDRESS) PHONE:

1)INSURANCE COMPANY ADDRESS:

SUBSCRIBER'S NAME ID# GROUP#

2)INSURANCE COMPANY ADDRESS:

SUBSCRIBER'S NAME ID# GROUP#

I hereby authorize direct payment of surgical/medical benefits to Dr Sharad Vyas for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.
I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.
A photocopy of these assignments shall be valid as the original.

PATIENT NAME: Date:
(Please Print)

PARENT/GUARDIAN:
PRINT NAME: SIGNATURE:

HIPPA COMPLIANT

PHARMACY NAME & LOCATION: