Pina Shah, M.D.
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Phone: 480-786-9084 Fax: 480-786-9086

PATIENT REGISTRATION FORM

(Please Print)

Name: ______________________________ Birth date: ______________________
Address: ______________________________ Phone: ______________________
______________________________ S.S. No. ______________________
______________________________ Email: ______________________

How did you hear about us? ______________________ Cell Phone: ______________________

PERSON RESPONSIBLE FOR BILL

Name: ______________________________ S.S. No. ______________________
Address: ______________________________ Relationship: ______________________
Date of Birth: ______________________________ Phone: ______________________

EMPLOYERS

Patient Employed by: ____
Address: ______________________________ Phone: ______________________

EMERGENCY CONTACT (Not Living with You)

Name: ______________________________ Home Phone: ______________________
Address: ______________________________ Work Phone: ______________________
Relationship to You: ______________________________ Cell Phone: ______________________

Check all that apply:

☐ I allow full disclosure of any of my medical or office information to the following persons:

☐ Spouse ☐ Other (name): ______________________ ____________ DOB ______________

____
Phone City

Signed: ______________________________ **Date:** ______________________
(Patient or Guardian)

INSURANCE

Primary: ____
Address: ____
Subscriber/Medicare Number: ______________ Group Number: ______________________
Secondary: ____
Address: ____
Subscriber/Medicare Number: Group Number:

Co-pay or non-insurance expenses are due at the time of service. There will be $30 charge for re-scheduling or canceling/no-show an appointment within 24 hours of scheduled appointment time.

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits.

Signed: ____ **Date:** ______________________
(Patient or Guarantor)

I authorize examination and treatment for this and all following physician visits.

ASSIGNMENT OF BENEFITS:
I authorize payment of medical benefits to Advanced Internal Medicine, PC for professional services rendered.

Release of Information:
I authorize the release of any medical information necessary to process claims or provide my care as required by law.

HIPAA: I have reviewed the office record and privacy policy and had my questions answered

I allow the office to correspond with my home phone or cell phone and allow the office to leave a message concerning reminders and routine reports

Signed: ____ **Date:** ______________________