Smriti Goel M.D., S.C.

PATIENT REGISTRATION

Last Name _____ First Name _____ Middle Initial____

Date of Birth _____ Social Security # _____Gender: □M □F

Race/Ethnicity_____ Language_____

Home Address _____

City, State, Zip _____

Pharmacy_____ City, Zip_____

Employer: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Preferred Contact Number: __Cell __Home __Work

May we leave message: ____yes____no **Email**: _____(for patient portal)

Significant other's Name: _____Phone: _____

Referred by: _____

Emergency Contact Information

Person (other than significant other) we may contact:

Name: _____

Address_____Phone_____

Insurance Information

Person Financially Responsible_____ Relationship to Patient_____
Address: _____Phone:_____
1st Insurance Carrier_____ Policyholder's Name_____
1st Policyholder's Date of Birth_____ SS#_____
2nd Insurance Carrier_____ Policyholder's Name_____
2nd Policyholder's Date of Birth_____ SS#_____

PATIENT ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I have received an information pamphlet explaining the office policies and informed consent for treatment form. I give permission to Dr. Goel, for in person & telehealth visits and to obtain my prior refill history from pharmacy. I hereby agree to treatment and understand that should I have any questions I will contact the office staff. I hereby authorize any insurance carrier to make payment direct to Smriti Goel, M.D., S.C. professional staff. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed including collection agency fees.** I further authorize Smriti Goel M.D. S.C. to release my insurance company(s) any information from my record which may be necessary to determine benefits payable under my policy. This information may include, but is not limited to diagnosis, treatment procedure and/or photocopy of all or part of my record.

Patient Signature_____Date_____