EAST METRO INTERNAL MEDICINE/ROCKDALE-NEWTON HEMATOLOGY/ONCOLOGY

Roopal A. Desai, M.D. 3641 Hwy. 20 SE, Ste A, Conyers, GA 30013 • **O: 770-918-1234 F: 770-918-123**

Anil J. Desai, M.D. 4139 Baker St., Covington, GA 30014 • **O: 770-786-9499 F: 770-786-975**

Patient Registration Form

PLEASE DO NOT LEAVE ANY SPACES BLANK. IF NO INFORMATION, PUT N/A IN SPACE

First Name _____ M.I. _____ Last Name _____

Mailing Address _____

City _____ State _____ Zip _____

Phone (H) _____ Phone (W) _____ Sex _____

D.O.B. _____ Social Security # _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Spouse's Name _____

Race: ❑ Caucasian ❑ Black ❑ Hispanic ❑ Oriental ❑ American Indian ❑ Eskimo ❑ Asian Indian

Other _____

Nearest Relative Not Living With You: Name _____

Relationship _____ Phone _____

Address _____

City _____ State _____ Zip _____

Your Employer _____

Address _____

Job Title _____ Supervisor _____

Is your visit related to a work injury? ❑ Yes ❑ No

What is the reason for today's visit? _____

_____

_____

_____

Insurance Information

Primary Insurance:

Insurance Company Name _____

Address for mailing claims _____

City _____ State _____ Zip _____

Phone Number _____ Effective Date _____

Policy Holder's Name _____

Policy or Contract ID# _____ Group Name or Number _____

Policy Holder's DOB _____ Social Security # _____

Relationship to Policy Holder _____

EAST METRO INTERNAL MEDICINE/ROCKDALE-NEWTON HEMATOLOGY/ONCOLOGY

Roopal A. Desai, M.D. 3641 Hwy. 20 SE, Ste A, Conyers, GA 30013 • **O: 770-918-1234 F: 770-918-1235**

Anil J. Desai, M.D. 4139 Baker St., Covington, GA 30014 • **O: 770-786-9499 F: 770-786-9757**

Address _____

Job Title _____ Supervisor _____

Secondary Insurance: ❑ Yes ❑ No (If yes, please complete. If no, please present primary insurance card to receptionist for copying purposes when you complete this form.)

Insurance Company Name _____

Address for mailing claims _____

City _____ State _____ Zip _____

Phone Number _____ Effective Date _____

Policy Holder's Name _____

Policy or Contract ID# _____ Group Name or Number _____

Who should we thank for referring you to us? _____

Responsibility Statement

In most cases, you are expected to pay for all office services at the time of your appointment. For your convenience, our office accepts MasterCard, Visa, personal checks and cash. Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. HAVING INSURANCE IS NOT A SUBSTITUTE FOR PAYMENT. Many companies have fixed allowances or percentages based on your contract with them, not our office. It is your responsibility to pay the co-pay, deductible, co-insurance, and any other balances not paid by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient X _____ Resp. Party _____
(Parent if minor)

Witness _____ Date _____

My signature below indicates that I have been given the chance to review a current copy of East Metro Internal Medicine's "Notice of Privacy Practices".

Patient _____ **Resp.Party** _____ **Date** _____
(Parent if minor)

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

NON-MEDICARE PATIENTS

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to Honey Creek Medical Practice. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made on my behalf to Honey Creek Medical Practice for services provided me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient X _____ Resp. Party _____
(Parent if minor)

Witness _____ Date _____