MORGAN HILL INTERNAL MEDICINE

NIMISHA SHAH, M.D. **DEVANG SHAH, M.D.**

REGISTRATION FORM

Today's Date _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❒ Mr. ❒ Miss ❒ Mrs. ❒ Ms.	Marital Status (Circle One) Single / Mar. / Div. / Sep. / Wid.

Is this your legal name? ❒ Yes ❒ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❒ Male ❒ Female

Street Address	City	State	Zip Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	Zip Code

Occupation	Employer	Employer Phone No. ( )

How were you referred to our practice? ❒ Dr. _____ ❒ Insurance Plan ❒ Hospital

❒ Family ❒ Friend ❒ Close to Home/Work ❒ Yellow Pages ❒ Internet/Website ❒ Newspaper

Other Family Members Seen Here? ❒ Yes ❒ No _____

Do You Have Insurance? ❒ Yes ❒ No

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is that person a patient here?	❒ Yes ❒ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❒ Yes ❒ No

Please indicate primary insurance: ❒ Atena ❒ PacifiCare ❒ Blue Cross ❒ Blue Shield ❒ CIGNA

❒ Health Net ❒ United Health Care ❒ Medicare ❒ MediCal ❒ Other _____

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other _____

Name of Secondary Insurance (if applicable) Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ 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. ( )

Do you wish us to disclose your medical history including lab/xray etc., to any person other than you? ❒ Yes ❒ No

If yes, please provide their name and relationship to patient:_____

The above information is true and 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 **MORGAN HILL INTERNAL MEDICINE** or insurance company to release any information required to process my claims.

I have received Notice of Privacy Policy.

_____ _____

PATIENT / GUARDIAN SIGNATURE DATE