THAKKAR, PATEL & AVALOS, MD'S LC
Patient Demographic Information

Last Name:_____ First Name:_____ MI____

Social Security #:_____ Date of Birth:_____ Gender: M F

Mailing Address: _____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Race: Caucasian African American Asian Native American Other
Ethnicity: Hispanic/Latino Other Not reported/returned

Employer Name:_____Emp. Phone:_____

Emp. Address:_____ City,State,Zip_____

Primary Care Physician:_____ Phone:_____

Referring Provider:_____ Phone:_____

☐ New Patient ☐ Existing patient ☐ Returning Patient (more than 3 years)

EMERGENCY CONTACT INFORMATION: In case of Emergency who should be notified?

Name:_____ Relationship:_____

Phone:_____ Phone:_____

BILLING INFORMATION

Primary Insurance Name:_____

Secondary Insurance Name:_____

EMAIL INFORMATION AND CONSENT

Email Address: _____
In giving this information I agree to have personal and medical information sent to me via the internet which is not a secure medium. I may rescind this permission at any time, in writing.
Patient or Authorized Person's Signature:_____ Date:_____

Release of Medical Records, Medical Information and Assignment of Insurance Benefits

I authorize payment of medical benefits to: THAKKAR, PATEL, & AVALOS, MD'S LC for services rendered. I also authorize the release of any medical information necessary to process my insurance claims. I request and authorize that payment/insurance benefits be made directly to THAKKAR, PATEL, & AVALOS, MD'S LC for any services furnished to the above named patient by THAKKAR, PATEL, & AVALOS, MD'S LC The signature below shall suffice for all insurance forms on a continuing basis. I agree to pay THAKKAR, PATEL, & AVALOS, MD'S LC for all charges for services not covered by Insurance Payer.

Patient or authorized persons signature_____ **Date:**_____