Mayur C. Patel, M.D., Inc.
Diplomate American Board of Internal Medicine

2625 W. Alameda Ave
Suite 506
Burbank, CA 91505-4816
Office: 818-843-5864

Registration (please print):

Date: _____ Home Phone: (____)_____ Cell: (____)_____

Patient: _____
(Last Name) (First Name) (Middle Name)

Date of birth: _____ Age:_____ Sex: ☐ M ☐ F ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Responsible Party (if a minor): _____

Address: _____ City: _____

State: _____ Zip Code: _____ E-Mail: _____

Employer / School: _____

Employer / School Address: _____

Occupation: _____ Work phone: (____)_____

Spouse (or responsible party) Name: _____ Birth date: _____

Business Name and Address: _____

Occupation: _____ Work phone: (____)_____

Who is responsible for this account? _____ Relationship to the patient: _____

Social Security #: _____ Spouse's Social Security #: _____

Do you have medical insurance? ☐ Yes ☐ No ⇨ If yes,

Name of Primary Insurer: _____ Policy holder: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Name of Secondary Insurer (if any): _____ Policy holder: _____

Contract #: _____ Group #: _____ Subscriber #: _____

☐ Medicare ☐ Medicaid Claim ID #: _____

If Welfare, your number: _____ County of: _____

In case of emergency, who should be notified?: _____ Phone: _____

How did you learn of our practice?: _____

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AUTHORIZATIONS

Insurance Assignment and Release

I certify that I have insurance coverage with_____

Name of Insurance Company (ies)

And assign directly to **MAYUR C. PATEL, M.D., INC.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare / Medigap Authorization:

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to **MAYUR C. PATEL, M.D., INC.** for any services furnished to me by that provider.

To the extent permitted by law, I authorized any holder of medical or other information about me to release to the Center for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____

Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary