Hemant D. Patel, M.D.
Family Practice

1968 N. Garey Ave
Pomona CA, 91767
909-620-3858

REGISTRATION FORM

PATIENT INFORMATION:

Name: _____

Age: _____ Date of Birth: _____

Telephone #: (___) _____

Cell #: (___) _____

Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security: _____

☐ Married ☐ Widow ☐ Single ☐ Divorced

CONTACT PERSON IN CASE OF EMERGENCY:

Name: _____

Relationship: _____

Telephone #: (___) _____

Cell #: (___) _____

INSURANCE INFORMATION

Name of insurance: _____ Policy/ ID#: _____

Medi-cal #: _____ Medicare #: _____

I WAS REFERRED BY:

Relative/ Friend Name: _____ Other: _____

I hereby give authorization to my physician and his associates to administer any medical, surgical or maternity treatment that the physician considers necessary for my health and well-being.

I free them from all medical responsibility if I desire to discontinue the treatment before such treatment is complete. Bill my insurance for the cost of treatment if my insurance DO NOT pay, I understand it is my responsibility to pay the bill for all treatment provided.

I fully understand that all my charges resulting from my treatment will be my responsibility and paid promptly as treatment is received.

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_____ _____ _____
Print Name Signature Date

REQUEST/ REFUSAL FOR INTERPRETIVE SERVICES

Patient Name: _____

Primary Language: _____

- ❑ Yes, I am requesting interpretive services.

  Language: _____

- ❑ I prefer to use my family or friend as interpreter.

- ❑ No, I don't require interpretive services.

- ❑ Not applicable, Please explain:

  _____
  _____
  _____
  _____
  _____

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_____	_____	_____
Print Name	Signature	Date