Neela Parekh, M.D. FAAP
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PATIENT REGISTRATION FORM

Patient's Name *(Last, First, M.I.)*		**Birth Date**
Siblings		**Birth Date**
		Birth Date
If new patient who referred you to us?	**Date of last physical exam**	
Father's Name *(Last, First, M.I.)*	**SSN**	**Birth Date**
Mother's Name *(Last, First, M.I.)*	**SSN**	**Birth Date**
Address		

	Dad	**Mom**
Home Phone		
Work Phone		
Cell Phone		
Email		

Employer Name	**Phone #**
Emergency Contact	
Primary Insurance Carrier	**Effective Date**

I authorize my insurance company to pay benefits directly to my Dr. Neela Parekh, M.D. I also authorize the release of any personal health information to my insurance company in order to process claims. I understand that all co-payments; deductible amount and/or non-covered medical services are to be paid at the time of service. If I am not eligible under the terms of my Insurance or Employer, I understand that I am fully liable for all the charges for services rendered.

Name (Please Print):_____

Signature:_____ **Date**:____/____/_____