RAJANI CHAUDHARI, MD & ANJALI CHAUDHARI, DO
PEDIATRICS AND ADOLESCENT MEDICINE

PATIENT REGISTRATION **TODAY'S DATE: _____**

PATIENT'S FIRST & LAST NAME: _____	**DOB: ___/____/____ SEX(circle): (M) or (F)**
NAME OF INSURANCE: _____	**INSURANCE ID#:** _____
PATIENT'S HOME ADDRESS: _____	
PRIMARY CAREGIVER(S) OF PATIENT: (circle all that apply below) **BIOLOGICAL MOTHER BIOLOGICAL FATHER RELATIVE OTHER:_____**	
NAME(S) OF PRIMARY CAREGIVER(S): _____ _____	
HOME PHONE#: _____ **CELL PHONE#: _____**	**EMAIL: _____**
PHARMACY NAME:_____ **ADDRESS: _____** **PHONE #: _____**	**EMERGENCY CONTACT(OTHER THAN PRIMARY CAREGIVER):** **NAME: _____** **PHONE #: _____**

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payments of surgical/medical benefits to ***DR. RAJANI CHAUDHARI, M.D./ DR. ANJALI CHAUDHARI, DO*** for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by patient's insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize ***DR. RAJANI CHAUDHARI, M.D./ DR. ANJALI CHAUDHARI, DO*** to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICAID

I certify that the information given in regards to payment is correct and authorize release of all reports on request. Payment of authorized benefits may be made on my behalf.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I have been made available a copy of Notice of Privacy of ***DR. RAJANI CHAUDHARI, M.D./ DR. ANJALI CHAUDHARI, DO PEDIATRIC AND ADOLESCENT MEDICINE.***

_____ _____

Signature **Today's Date:**