ARTHRITIS & RHEUMATOLOGY SPECIALISTS PC
SHARUKH SHROFF MD

Patient Registration Form

PATIENT INFORMATION **Referring Physician**_____

Patient Name: Last_____ First _____ Middle _____

Address _____ City_____State_____ZIP_____

Sex: (Please Circle) Male/Female Title: (Please Circle) Dr. Mr. Mrs. Ms.

Social Security # ____ _____ ____ - ____ ____ - ____ ____ ____ ____

Birth date ____ ____ - ____ ____ - ____ ____ Home Phone (_____)_____

Work Phone (_____)_____ Marital Status _____

Employer/Address _____ City _____ State _____

Emergency Contact _____ Phone Number (_____)_____

RESPONSIBLE PARTY

Guarantor's Name _____ Phone Number (_____)_____

Address _____City _____State_____ ZIP _____
(If different from above)
Patient Relation to Guarantor _____ Guarantor Employer _____

Employer Address: City _____ State _____ ZIP _____

Guarantor SS# ____ ____ ____ - ____ ____ - ____ ____ ____ ____ Guarantor Birth date _____

PRIMARY
Name of Insurance Company _____ Policy Holder _____
ID Number _____ Group Number _____

SECONDARY

Name of Insurance Company _____ Policy Holder _____
ID Number _____ Group Number _____

I hereby authorize Arthritis & Rheumatology Specialists PC, to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Arthritis & Rheumatology Specialists PC, of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient's signature (or responsible party) _____ Date _____