Morgan Hill Internal Medicine

https://www.morganhillinternalmedicine.com

NIMISHA SHAH, M.D.

DEVANG SHAH, M.D.

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: _____ First: _____ Middle: _____ Sex ☐ Male ☐ Female

Email Address: _____ Birth Date ___/___/_____ Age ____ Cell No: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Name of Pharmacy: _____ City: _____

Name of Mail In Pharmacy: _____

Do you Have Insurance? ☐ Yes ☐ No If yes. Please provide either insurance card or Front and Back copy of insurance card.

If minor is (under age 18) Guarantor Information

Last Name: _____ First Name: _____

Address: _____ City: _____ State: ____ Zip Code: _____

IN CASE OF EMERGENCY

Name | Relationship to Patient | Cell No: _____

The above information is true and to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MORGAN HILL INTERNAL MEDICINE or insurance company to release any information required to process my claims.

Any phone calls, emails, patient portal communication regarding clinical assessment or ordered test, follow ups, prescription refills advice will be documented in your medical record and therefore may generate a telehealth fee to your insurance company. These services are available to provide you the best and most convenient service possible, in accordance with HIPPA guidelines in an effort to protect you PHI.

I have reviewed Notice of Privacy Policy on office website, https://www.morganhillinternalmedicine.com

I give consent to retrieve my external medication history.

_____ _____

Patient / Guardian Signature Date