Arthritis & Rheumatology INSTITUTE

Patient Registration Form

Megha Patel-Banker, MD
5930 W Parker Rd, Suite 600
Plano, TX 75093
Phone (972) 798-8553
Fax (972) 798-8556
www.DFWArthritis.com

Patient Information

First Name:______________________________ Last Name:___________________________________

Home Address:____ APT #:___________

City:___________________________________ State: __________ Zip:____________________

Email Address:_____________________________ Preferred Language:_____________________

Social Security #: ___________________________ Date of Birth:____________________________

Cell:________________________________ Home Phone:_________________________________

Work:________________________________

I authorize Arthritis and Rheumatology Institute to send and appointment reminder to me via text message

Gender: [ ] Male [ ] Female Race/Ethnicity: _______________ Marital Status: ___________

Emergency Contact Information:

First Name:______________________________ Last Name:___________________________________

Phone:_________________________ Relationship to Patient:______________________________

Care Team:

Primary Care Physician:__________________________ Phone #:__________________________

Referring Physician:_____________________________ Phone #:__________________________

Other Physicians:________________________________

Primary Insurance Information:

Insurance Carrier:________________________ Policy Type:__________________________________

Member Number: _______________________ Group Number:______________________________

Primary Insured First Name:____________________ Last Name:____________________________

Patient Relationship to insured:____________ Date of Birth of Primary Insured:______________

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Secondary Insurance Carrier

Insurance Carrier:_________________________ Policy Type:_____________________________________

Member Number: ________________________ Group Number:________________________________

Primary Insured First Name:_____________________ Last Name:______________________________

Patient Relationship to insured:____________ Date of Birth of Primary Insured:______________

Preferred Pharmacy Information:

Pharmacy Name:_______________________________Phone:_____________________________________

Street Address:____

City:______________________________________ State: __________ Zip:______________________

I hereby consent to the treatment as prescribed by my physician and provided by Arthritis and Rheumatology Institute, its employees, or representative. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I understand that I am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill. I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carriers(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Arthritis and Rheumatology Institute for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance. I hereby authorize the release of any and all information to my insurance company or other appropriate party, as required, pertaining to treatment rendered to me by Arthritis and Rheumatology Institute. Further, I authorize Arthritis and Rheumatology Institute to obtain needed information from my physician, employer or insurance company.

Signature of Patient:______________________________________ Date:__________________________