AMITABH SHUKLA, M.D., P.A.
Board Certified in Neurology and Electromyography

NEUROLOGY CLINIC

16605 Southwest Freeway, Suite 210, Sugar Land, TX 77479 1601 Main Street, Suite 201, Richmond, TX 77469

REGISTRATION FORM

Please complete this form and return it to the front desk. Please print and do not leave any items blank

PATIENT INFORMATION

Patient Name Last:	First:	Middle Name:	
Street Address:	City:	State:	ZIP Code:
Home phone:	Work phone:	Mobile phone:	
Social Security:	Birth Date:	Age:	
Sex: ❑ M ❑ F	Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black ❑ Caucasian ❑ Pacific Islander ❑ Declined ❑ Other *(Please check one)*		
Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Declined *(Please check one)*	Language: ❑ Arabic ❑ Cantonese ❑ English ❑ French ❑ German ❑ Hindi ❑ Italian ❑ Japanese ❑ Korean ❑ Mandarin ❑ Persian ❑ Polish ❑ Portuguese ❑ Romanian ❑ Russian ❑ Spanish ❑ Tagalog ❑ Ukrainian ❑ Urdu ❑ Vietnamese ❑ Other *(Please check one)*		
Marital status: ❑ Divorced ❑ Married ❑ Separated ❑ Single ❑ Widowed	Home Email:		
Employer Name:	Occupation:		
Employer Address:	City:	State:	ZIP Code:
Emergency Contact Name:	Emergency Contact Number:		
Primary Care Physician:	Phone Number:		
Referring Physician:	Phone Number:		

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No (Please give your insurance card to the receptionist)

Primary Insurance Carrier		Secondary Insurance Carrier	
Primary Insurance Name:		Secondary Insurance Name:	
Insurance ID:	Group#:	Insurance ID:	Group#:
Group Name:		Group Name:	
Insured Name:		Insured Name:	
Insured SSN:	Insured DOB:	Insured SSN:	Insured DOB:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I hereby authorize Amitabh Shukla, M.D., P.A. doctors and staffs to examine me and make such tests and perform such procedures as are reasonable and necessary for diagnosis of my condition and also consent to required treatment. Release of any medical information is necessary in the course of my examination or treatment and for the process of this claim.

ASSIGNMENT OF BENEFITS: I hereby authorize payment from any insurance company or governmental agency directly to Amitabh Shukla, M.D., P.A. for any benefits. I also authorize Amitabh Shukla, M.D., P.A. to release any medical information necessary to expedite such insurance claims. I hereby agree to pay co-payments, co-insurances, or deductibles that apply to my insurance plans. Also, I hereby agree to pay the entire or remaining amount of my fees if such fees are not covered or paid by my insurance benefits within 90 days of billing. I permit a copy of above to be used in place of original, which has been filed in the office of Amitabh Shukla, M.D., P.A. I also understand that Amitabh Shukla, M.D., P.A. is required by applicable federal and state law to maintain the privacy of my "Protected Health Information" (PHI). A notice about their privacy practices, legal duties and my rights concerning my "PHI" is on display and offered to me at the front office.

Patient/Guardian signature	*Print Name*	*Date*