NEW PATIENT REGISTRATION

Joanne Crenshaw, M.D
Shaleen Belani, M.D.

Date: ____________

Last Name ______________________________ First Name ________________ M.I. ____ Sex: M ___ F ___
Social Security # ____________________ (Confidential; for billing purposes only) DOB __________ Marital status: S M W D

Street Address: ______________________________________ City: _______________ State: _____ Zip: ______
Home Phone#: ____________________ Work Phone#: ________________ Cell phone#: ______________
Employer: ______________________ Occupation: ____________ May we call your place of employment? Y N

Email: __________________________________ (Your email gives you access to the patient portal to access/update your medical records.)

Local Pharmacy Name: _________________________ City: _____________________ Phone: __________
(NOT MAIL ORDER)
Primary Doctor's Name/Address/Phone: ____
Referring Provider's Name/Address/Phone (if different than above): ___________________________________

Language: English: ___ Other: ___
Ethnicity: Hispanic ___ Non-Hispanic ___
Race: White ___ Black/African American ___ American Indian/Alaska Native ___
Asian ___ Native Hawaiian/Other Pacific Islander ___ Decline response ___

PRIMARY INSURANCE INFORMATION

Insurance Co. Name: __________________________ Policy #: __________________ Group #: ____________
Policy holder's Name: ___________________________________ Relationship to Patient: ________________
Policy holder's Social Security # ___________________ DOB ________________
Street Address: ______________________________________ City: _______________ State: _____ Zip: ______
Home Phone#: ____________________ Work Phone#: ________________ Cell phone#: ______________

SECONDARY INSURANCE INFORMATION

Insurance Co. Name: __________________________ Policy #: __________________ Group #: ____________
Policy holder's Name: ___________________________________ Relationship to Patient: ________________
Policy holder's Social Security # ___________________ DOB ________________
Street Address: ______________________________________ City: _______________ State: _____ Zip: ______
Home Phone#: ____________________ Work Phone#: ________________ Cell phone#: ______________

Person(s) you would like to authorize to receive/discuss medical information: ______________________________
Person to contact in case of an emergency: ____________________ Relationship/phone#: _________________

I hereby authorize Joanne Crenshaw, MD, PC to apply for benefits on my behalf for services rendered and authorize the release of any information acquired in the course of my treatment necessary to process insurance claims. I request payment from the above indicated insurance carrier to be made directly to Joanne Crenshaw, MD, PC, realizing that I am responsible for all non-covered charges. I also realize I am responsible for any other costs incurred while collecting my outstanding balance(s). I acknowledge their notice of privacy practices is available to me upon request. I certify that the information I have reported is correct to the best of my knowledge. This is to remain in effect indefinitely unless revoked in writing by the undersigned.

Patient, Parent or Guardian Signature: ________________________________ Date: ______________