Premier Cardiology & Vascular Associates

Changing Lives Everyday

Amish M. Parikh, MD, FACC

Patient Registration Form

Last Name:		**First Name:**		**Middle initial:**	**Date:**
Sex: ☐M ☐F	**DOB:** ____ /____ /_____	**Age:**	**SSN:**	**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**	
Home Phone#:		**Cell / Alternative Phone #:**		**Email:**	
Street (Address):		**City:**		**State:**	**Zip Code:**
Status: ☐Employed ☐Unemployed ☐Retired ☐Student		**Employer Name:**		**Work Phone #:**	
Primary / Family Doctor Name:			**Pharmacy Name:**		
Office Phone #:			**Pharmacy Phone #:**		
May we call you at home and leave a message? ☐ YES ☐ NO (Please see the bottom of the page to authorize us to speak with others about your care.)					
How did you hear about us? ☐Family ☐Friend ☐Employer ☐Phone Book ☐Doctor (Name)_____ ☐Other_____					
Primary Insurance Information:			**Secondary Insurance Information:**		
Insurance Name:			**Insurance Name:**		
Phone #:			**Phone Number:**		
Group Number:	**ID / Policy Number:**		**Group Number:**	**ID / Policy Number:**	
Name of Policy Holder (if different from patient's name):			**Name of Policy Holder (if different from patient's name):**		
Policy Holder DOB: _____ /_____ /_____	**Policy Holder's SSN (REQUIRED):**		**Policy Holder DOB:** _____ /_____ /_____	**Policy Holder's SSN (REQUIRED):**	

Workers Comp Information: Please fill out this section if this is related to worker's comp case:

Name of Contact:	Contact Phone Number:	Claim#
Employer's Name:	Employer's Phone Number:	Date of Injury:

Emergency Contact Information:

Name:		Name:	
Phone #:	Relationship to Patient:	Phone #:	Relationship to Patient:

Contact Information for (family/friends) to discuss your medical care:

Name:	Phone #:	Relationship to Patient:
Name:	Phone #:	Relationship to Patient:
Name:	Phone #:	Relationship to Patient:

670 N. Orlando Avenue, Suite 1003
Maitland, FL 32751
Phone: 407-622-0793 Fax: 866-362-3655