**PATIENT REGISTRATION FORM**

**TRUE MEDICAL CARE P.C.**

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|  | **WEIGHT**  **HEIGHT** | **:**  **:** |

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| **PATIENT INFORMATION** | | | | | | | |
| PATIENT’S NAME: | | | | | | | CHART#: |
| ADDRESS: | | | | | | | APT#: |
| CITY: | | STATE: | | | | | ZIP: |
| HOME#: | MOBILE#: | | | | | WORK#: | |
| DOB: | GENDER: | | | | | MARITAL: | |
| SSN: | | | | | PCP: ***CHOWDHURY, UTPAL*** | | |
| EMPLOYED: | | | PHARMACY: | | | | |
| MEDICAID / MEDICARE: | | | ID# | | | | |
| INS NAME: | | | ID# | | | | |
| **PATIENT INFORMATION (For Children Only)** | | | | | | | |
| PARENTS NAME: | | | | | | | |
| ADDRESS: | | | | | | | APT#: |
| CITY: | | STATE: | | | | | ZIP: |
| MOBILE#: | | | | WORK#: | | | |

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| I understand and agree that (regardless of my insurance status), I am responsible for the balance on my account for any professional service rendered. I have read all of the information on this sheet and have filled out the above form. I certify that this information is true and correct to the best of my knowledge, and will notify you of any changes of said information.  I request that payment of authorized Medicare benefits and all other insurance carriers be made on my behalf to **TRUE MEDICAL CARE P.C. (UTPAL CHOWDHURY, MD)** for services furnished to me by the provider. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services to the Health Care Financing Administration, its agents, and all other insurance carriers. If the insurance check is mailed to me instead of the doctor, I will send the check in within one week or be charged interest. |

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| **SIGNATURE:** | **RELATIONSHIP:** | **DATE:** |

**TRUE MEDICAL CARE P.C.**

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| **Utpal Chowdhury, MD**  *Internal Medicine*  40-37, 76th Street, 1st Floor,  Elmhurst, NY 11373  Tel: 718-533-0002, 917-503-5002  Fax: 718-533-0005, 917-503-5004 | **Utpal Chowdhury, MD**  *Internal Medicine*  167-02 Highland Ave,1st Fl,  Jamaica, NY 11432  Tel: 718-297-4444, 917-503-5006  Fax: 718-297-4443, 917-503-5005 |

**RELEASE FORM**

I authorize any doctor, hospital or other health/ social agency to release to True Medical Care PC any information or records as may be required.

I also authorize True Medical Care PC to release to any doctor, hospital or other health / social agency any records or information as may be requested by them.

A photocopy of this authorization shall be considered as effective and valid as the original.

|  |  |
| --- | --- |
| NAME:…………………………………………………………….. | RELATION:………………………… |
| DOB:……………………………………………………………… |  |
| Applicant’s Signature:……………………………………... |  |
| Date:……………………………………………………………… |  |
| Please Include:   * Labs * EKG * Consultation:………………………………………… | * Progress Note * Others:…………………… * Radiology |

**UTPAL CHOWDHURY, MD**

**TRUE MEDICAL CARE, P.C.**

40-37, 76th Street, 1st Floor, Elmhurst, NY 11373

Tel # 718-533-0002 ~ Fax # 718-533-0005

167-02 Highland Ave, 1st Floor, Jamaica, NY 11432

Tel # 718-297-4444 ~ Fax # 718-297-4443

**PRACTICE’S REQUIREMENTS**

The Practice:

1. Is required by federal law to maintain the privacy of your PHI and to proved you with this Privacy Notice detailing the Practice’s legal duties and privacy practices with respect to your PHI.
2. Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
3. Is required to abide by the terms of this Privacy Notice.
4. Reserves the right to change the terms of this privacy Notice and to make the new Privacy Notice provisions effective for all your PHI that it maintains.
5. Will distribute any revised Privacy Notice to you prior to implementations.
6. Will no retaliate against you for filling a complaint.

**EFFECTIVE DATE**

This Notice is in effect as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT ACKNOWLEDGEMENT**

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

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| --- | --- |
| Patient Name (Please Print) | DOB |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |