Meeta Singh MD PC
31350 Telegraph Road Ste, Michigan 48025
p: 248.480.2220
www.meetasinghmd.com
Meeta Singh MD PC

PATIENT REGISTRATION FORM

(**Please Print**)

Today's Date:________________

Name:____**Birth Date**:_________________**Soc. Sec.#**___________________

Address:____**City**:_______________________**State**:_________**Zip**:___________

Home Phone:_____________________________**Cell**:_______________________**Work**:_____________________________

Preferred Method of Contact (*Circle One*): Home Cell Work

Race (*Circle One*): American Indian/ Native American Asian Black/African American

Nat. Hawaiian/ Pacific Islander White/Caucasian Other Race Declined

Ethnicity (*Circle One*): Hispanic or Latino Not Hispanic or Latino Declined

Primary Language:____

Employer:____**Employer's Phone**:________________________________

Subscriber's Name:______________________________________**Subscriber's Soc. Sec.#**_____________________________
(***If different from the patient***)

Subscriber's Birth Date:____

In Case of Emergency, Contact (Name):___________________________________**Phone#**___________________________

Payment Information

I understand that I am responsible for full payment of any services rendered. I also understand that Dr. Singh does not accept any insurance.

Patient's Name:____

Signature:____**Date**:______________________________________

Authorization to Release Information

I hereby authorize the release of any medical information to be forwarded to another physician or healthcare provider for further treatment / evaluation or to my insurance company in order to process payment for services rendered.

Signature on File____Date:____________________________________