Bella Vista Internal Medicine
Jigna Patel, MD PLLC
2680 S Val Vista Dr, Ste 131 Bldg 6
Gilbert, AZ 85296

PATIENT ENROLLMENT INFORMATION

NAME (Last, First, Middle Initial)		BIRTHDATE	SS #	GENDER ☐ MALE ☐ FEMALE
ADDRESS		CITY, STATE, ZIP		
PRIMARY PHONE - May we leave a detailed message at this phone? ☐ Yes ☐ No	ALTERNATE PHONE	PRIMARY LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER		
EMPLOYER	WORK PHONE May we contact you at work? ☐ Yes ☐ No	EMAIL ADDRESS		

GUARANTOR INFORMATION (person who is financially responsible for patient amount due)

NAME (Last, First, Middle Initial)		BIRTHDATE	SS#	GENDER ☐ MALE ☐ FEMALE
ADDRESS (if different from patient)		CITY, STATE, ZIP		
PRIMARY PHONE	ALTERNATE PHONE	EMAIL ADDRESS		
EMPLOYER		WORK PHONE NUMBER	RELATIONSHIP TO PATIENT ☐ SPOUSE ☐	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY NUMBER	GROUP NUMBER
NAME OF OWNER OF POLICY		RELATIONSHIP OF OWNER OF POLICY TO PATIENT	
OWNER OF POLICY DATE OF BIRTH	GENDER ☐ MALE ☐ FEMALE	OWNER OF POLICY EMPLOYER	
COPAY AMOUNT	DEDUCTIBLE AMOUNT		

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY NUMBER	GROUP NUMBER
NAME OF OWNER OF POLICY		RELATIONSHIP OF OWNER OF POLICY TO PATIENT	
OWNER OF POLICY DATE OF BIRTH	GENDER ☐ MALE ☐ FEMALE	OWNER OF POLICY EMPLOYER	
COPAY AMOUNT	DEDUCTIBLE AMOUNT		

AUTHORIZED INDIVIDUALS TO WHOM MEDICAL INFORMATION MAY BE RELEASED TO:

NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE

PHARMACY INFORMATION

NAME OF PHARMACY

ADDRESS

OTHER INFORMATION

HOW WERE YOU REFERRED TO **BELLA VISTA INTERNAL MEDICINE (JIGNA PATEL, MD)**

☐ Friend

☐ Physician, Name ____

☐ Yellow Pages

☐ Newspaper, Name ______________________________________

☐ Other ____

I hereby agree that this information is correct and I understand that I must provide in writing any changes to the above information. I hereby understand that if I provide incorrect insurance information that I will be financially responsible for the balance due for each date of service:

____
Patient Name (Please print)

____
Signature of Patient and/or Legal Guardian

____
Date