Rakesh Shah, MD ● BT Turakhia, MD ● Jinesh Shah, MD ● Francis Uricchio, MD
Salik Nazir, MD ● Andrew Badalamenti, MD

NEW PATIENT REGISTRATION *(PLEASE PRINT)*

Name:______________________________ **Date of Birth**:__________ **SSN**:_______________

Address: ______________________________ **City**: __________________ **State**: ______**Zip**: _________

Home #: ____________________ **Work #**: ____________________ **Cell #**: ____________________

Email Address: ____ **Gender**: _________

Marital Status: (Please circle one) S M D W **Ethnicity**: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Other ___________________

Do you have a living will or advance directive? ☐ Yes ☐ No ***(Please provide a copy)***

Does anyone have Power of Attorney for you? ☐ Yes ☐ No ***(If YES, please provide name and copy)***

Employer:___________________________**Phone#**:______________**Address**: _________________________

Primary Care Physician: _________________________ **Phone #**: ___________________________

Referring Physician: _______________________ **Phone#**: _____________________

Emergency Contact: _______________________**Phone #**: ________________ **Relationship**: _____________

Pharmacy Name: ___________________**Address**: __________________________**Phone#**______________

RESPONSIBLE PARTY *(If different from patient)*

Name: _________________________________ **Date of Birth**: ____________ **SSN**: ______________

Home #: ________________________________ **Work #**: _________________

Address: _______________________________ **City**: ________________ **State**: _______ **Zip**: _______

Employer: ____

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:	Insurance Company:
Policy Holder Name:	Policy Holder Name:
Date of Birth:	Date of Birth:
Member ID #:	Social Security #:
Relationship to Policy Holder:	Relationship to Policy Holder:

GENERAL CONSENT FOR CARE AND TREATMENT

The patient has the right to be informed about the condition and the recommended surgical, medical, or diagnostic procedure, so that after knowing the risks and hazards involved, you may decide whether to undergo the suggested treatment. As of right now, no treatment plan has been recommended. We are simply providing you with information about your rights as a patient to help you make an informed healthcare decision. You should understand your condition and the treatment options available to you as a patient. Understanding the risks and benefits of each option is essential to making an informed decision. Medical terminology and potential risks and benefits of different treatment options will be explained to you by your healthcare provider. You will be informed about the expected outcomes and any potential complications.

It is important that you ask any questions you may have and seek clarification on any aspects of your condition or proposed treatment plan that you do not understand. Your healthcare provider is there to support you and provide you with the information you need to make an informed decision about your healthcare. Once you have been fully informed about your condition and the available treatment options, you have the right to take the time necessary to consider your options and make a decision that is in line with your personal values and preferences.

Your healthcare provider will respect and support your decision, regardless of whether you choose to proceed with a recommended treatment or procedure or not. By signing this consent form, you acknowledge that you have been provided with the necessary information to make an informed decision about your healthcare. You understand that no specific treatment plan has been recommended at this point, and that this consent form is simply to ensure that you are fully informed about your rights as a patient. Please take the time to read this form carefully and ask any questions you may have before signing. Your healthcare provider is available to discuss any concerns or queries you may have.

SIGNATURE: ____**DATE**: ________________

450 Blossom St. Ste. D, Webster, Texas 77598-4200