Ruchi Agarwal, MD
Well Care Ob & Gyn PC

303 2nd Avenue, Suite 9New York NY 10003 1749 Grand Concourse, Suite A, Bronx 10453

Registration Form

Patient Last Name	First Name/ Middle Initial	
Street Address Apt #	City, State and Zip	
Home phone	Email	Cell Phone
Social Security #	Date of Birth Age	Sex M____F____ Marital Status S__M__D__W__
Employer Name	Employer Address Phone	
Emergency Contact:	Phone Number	Relationship
Referring Dr	Dr Address	Dr Phone Number

PRIMARY INSURANCE

Insurance Name	Policy ID Number Group #
Policy Holder Name	Policy Holder Date of Birth

SECONDARY INSURANCE

Insurance Name	Policy ID Number Group #
Policy Holder Name	Policy Holder Date of Birth

INSURANCE

I request that payment of authorized Insurance Benefits be made on my behalf to Ruchi Agarwal, MD or Well Care OB & GYN PC for services furnished to me. I authorize any holder of medical information about me to release to the above Insurance Company(s) and its agents any information needed to determine these benefits or the benefits payable for received services. I understand I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

Patient's Signature_____Date_____

CONSENT FOR TREATMENT

I understand that diagnosis and treatment of me by any physician provider or staff member may be conditioned upon my consent as evidenced by my signature on this document. I have the right to revoke this in writing at any time except to the extent that any action has been taken in reliance upon this consent.

Patient's Signature_____Date_____