



Affiliated Physician
MDVIP

Viraj V. Tirmal, MD
Internal Medicine

Viraj V. Tirmal, MD LLC

NEW PATIENT REGISTRATION

Welcome to the practice of Dr. Viraj V. Tirmal! We hope to exceed your expectations and serve as your primary care provider for many years to come. Please fill out this form so we can get to know you better and register you in our system.

1. Why are you looking for a new doctor?

2. What are you looking for in your doctor's office?

3. How did you hear about our practice?

a. If applicable: whom can we thank for your referral? _____

Patient Information	
Name (print):	Date of Birth:
Address:	Social Security Number:
Home Phone: <input type="checkbox"/> Check if it is ok to leave voicemails regarding health information	E-mail Address:
Cell: <input type="checkbox"/> Check if it is ok to leave voicemails regarding health information	Work Phone: <input type="checkbox"/> Check if it is ok to leave voicemails regarding health information



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<p>To minimize disruption to your daily life but also keep you informed, we use automated SMS text message, phone, and e-mail to communicate non-clinical messages like appointment reminders.</p> <p>Please do not send automated messages by:</p> <p><input type="checkbox"/> Phone</p> <p><input type="checkbox"/> Text Message</p> <p><input type="checkbox"/> E-mail</p>	
<p>Which number is best to reach you during the day?</p> <p><input type="checkbox"/> Home</p> <p><input type="checkbox"/> Cell</p> <p><input type="checkbox"/> Work</p>	<p>Please select one:</p> <p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Other _____</p>
<p>Sex Assigned at Birth:</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p>	<p>Gender Identity:</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Other _____</p>
<p>Race:</p> <p><input type="checkbox"/> Black/African American</p> <p><input type="checkbox"/> White/Caucasian</p> <p><input type="checkbox"/> Native Hawaiian/Other Pacific Islander</p> <p><input type="checkbox"/> American Indian/Alaska Native</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Other</p>	<p>Ethnicity:</p> <p><input type="checkbox"/> Hispanic</p> <p><input type="checkbox"/> Non-Hispanic</p>
<p>Employment Status:</p> <p><input type="checkbox"/> Full Time</p> <p><input type="checkbox"/> Part Time</p> <p><input type="checkbox"/> Retired</p> <p>Other: _____</p>	
<p>Primary Insurance</p>	
<p>Insurance Company Name:</p>	
<p>Policy #:</p>	<p>Group #:</p>
<p>Subscriber/Policy Holder Name & Relationship (if other than Patient):</p>	
<p>Subscriber/Policy Holder Address:</p>	<p>Subscriber/Policy Holder Date of Birth:</p>



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Secondary Insurance	
Insurance Company Name:	
Policy #:	Group #:
Subscriber/Policy Holder Name & Relationship (if other than Patient):	
Subscriber/Policy Holder Address:	Subscriber/Policy Holder Date of Birth:
Preferred Pharmacy	
Pharmacy Name:	Pharmacy Phone Number:
Pharmacy Address:	
Emergency Contact	
Emergency Contact Name:	Relationship:
Phone Number:	Address:
Other providers that we may share records with:	
Specialty Care Provider Name #1:	Type of Specialty:
Phone Number:	Fax Number:
Specialty Care Provider Name #2:	Type of Specialty:
Phone Number:	Fax Number:



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Specialty Care Provider Name #3:	Type of Specialty:
Phone Number:	Fax Number:
Specialty Care Provider Name #4:	Type of Specialty:
Phone Number:	Fax Number:
Specialty Care Provider Name #5:	Type of Specialty:
Phone Number:	Fax Number:
Please list all medications you currently take, including vitamins and supplements and their dosage:	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	