ALPHA MEDICAL CLINIC

Dhiraj A. Patel, M.D.
Internal Medicine/ Family Practice
401 South Main Street, Ste A4
Alpharetta, GA 30009
Diplomate of the American Board of Internal Medicine

PATIENT INFORMATION

NAME: _____ Gender:___
Last Name First Name M.I.

ADDRESS:_____

_____
City, State Zip Code

DATE OF BIRTH:_____ AGE_____ SSN:_____

HOME:_____ WORK: _____ CELL:_____

HOME E-MAIL (for appointment reminders only)_____

EMERGENCY CONTACT:_____
Name Phone #

EMPLOYER'S NAME/PHONE#:_____

REFERRED BY:_____

Insurance Information

Do you have insurance? Yes { } No { }

Subscriber's Name_____

Name of Insurance Co. Type of Policy (PPO,POS,HMO)_____

Member ID. #_____Telephone Number_____

Group #_____

AUTHORIZED SIGNATURE

I VOLUNTARILY GIVE CONSENT FOR ME OR MY CHILD'S TREATMENT BY DR. DHIRAJ PATEL, MD. I FULLY UNDERSTAND THAT PAYMENT/ COPAYMENT ARE REQUIRED AT TIME OF SERVICE AND SHOULD MY INSURANCE BE FILED, ANY UNPAID BALANCE IS MY PERSONAL RESPONSIBILITY. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO MY INSURANCE COMPANY WHEN NECESSARY. IN THE EVENT THAT INSURANCE IS FILED BY DR. PATEL'S OFFICE I AUTHORIZE BENEFITS TO BE PAID DIRECTLY TO ALPHA MEDICAL CLINIC.

_____ _____
Signature Date