Panchshil Patel, M.D.
201 Bombay Ln., Roswell, GA 30076
Ph: 770-686-3246 Fax: 770-674-7366

PATIENT INFORMATION

Patient name_____ Male_____ female_____
Address_____ City_____ State_____ Zip_____
Date of birth_____ Social security #_____
Race:_____ Primary language spoken_____
Email:_____
Home number_____ Cell number_____
Place of employment_____ work number_____
Spouse name_____ Spouse work number_____
Spouse place of employment_____
(If Minor, parent or legal guardian)_____ Relationship_____
In case of emergency contact_____ Relationship_____ phone#_____
Pharmacy name & address_____
Type Of insurance_____ policy#_____
Name of Insured_____
Secondary insurance_____ policy#_____
Name of Insured_____
Medicaid#_____ Medicare#_____
Do you have living will?_____Do you have a Durable(Healthcare) power of Attorney_____

Payment is due at the time of the visit. If deductibles have not been met, you must pay your portion for the visit and Shivani Healthcare of Georgia will file your insurance company.

I understand that I am responsible for payment to Shivani Healthcare Of Georgia. If my insurance does not pay for a visit, medical testing, labs, medications, medical goods, etc., I understand that I am responsible for any unpaid amount. I understand that I am responsible for paying all co-pay required by my insurance company at the time of my visit.

I give permission to Shivani Healthcare Of Georgia to obtain medical information, lab work, and/ or test performed by other medical personnel, physicians, physician assistants, etc., or facilities. In compliance with the HIPPA Law.

Person Responsible for Payment_____

Signature_____Date_____

** **IMPORTANT, if this office visit is due to work injury, auto accident or workers compensation, please inform the receptionist.**