Minesh Patel, MD
Primary Care Medicine
404 NW Hall of Fame Drive
Lake City, FL 32055

Phone: 386 754 3627
Fax: 386 754 3657

DATE:_____

NAME:_____ AGE_____ D.O.B._____

ADDRESS:_____

PHONE #_____NEAREST RELATIVE_____PH.#_____

PATIENT'S SEX_____RACE_____MARITAL STATUS_____

PATIENTS SOCIAL SECURITY NUMBER_____

PLACE OF EMPLOYMENT_____PH.#_____

INSURANCE INFORMATION

MEDICARE # _____MEDICAID #_____

GROUP INSURANCE NAME & NUMBER_____

OTHER INSURANCE NAME & NUMBER_____

ANY KNOWN ALLERGIES_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MINESH PATEL, MD FOR SERVICES RENDERD.

SIGNED: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I AUTHORIZE MINESH PATEL, MD TO RELEASE ANY INFORMATION AQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO THE ABOVE NAMED INSURANCE COMPANIES FOR PROCESSING ANY INSURANCE CLAIMS.

SIGNED: _____