ADVANCED ALLERGY & ASTHMA

Kumar Patel, M.D.

Patient Name (first, middle, last) _____

Age_____ Date of Birth_____

Address_____

Home Phone # _____ Cell Phone # _____

Email Address _____ Marital Status_____

Patients Occupation _____ Work Phone # _____

Employers Name _____

Emergency Contact (Name, number, relation)_____

Primary Care Physician (Name and Number)_____

Referring Physician (Name and Number)_____

Pharmacy (Name and Number)_____

FINANCIAL RESPONSIBILITY:

Name_____ Date Of Birth_____

Relationship_____

Address (If different from above)_____

Phone # (If different from above)_____

INSURANCE INFORMATION:

Name of Insurance Company_____

Policy Holders Name/Relationship_____ Date of Birth_____

Member ID Number _____ Group Number _____

Secondary Insurance_____

I consent to treatment necessary for the care of the above patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I understand that payment of copays incurred is due at the time of services. I further agree to pay all reasonable attorney fees and collection costs in the event of a default on my account. I further authorize and request that insurance payments be made directly to Advanced Allergy & Asthma, Dr Kumar Patel. I have read and fully understand the above, consent for treatment, financial responsibility, release of medical information and insurance authorization.

_____ _____

Signature of Patient/Parent/Guardian Date