Capitol Allergy and Asthma Center
Maadhava Ellaurie, MD

PLEASE PRINT CLEARLY

Last Name	First Name	MI	Date of Birth

Address	City, State, Zip	Home Phone#

SS#	Marital Status: S/ M/ W/ D	Employment Status: Full/ Part/ Retired/ Unemployed/ Student	Male/Female	Work Phone#/Cell Phone#

Employer Name	Employer Address

If Patient is a minor, Parent/Guardian Name	Home Phone #

Address, if different from patient	Work Phone#/Cell Phone#

Allergies	Medications

Referring Physician Full Name:	Referring Phys Phone Number:

The next section requires accurate and current information. Please complete all sections for medical payment from your insurance company electronically and/or paper submission.

Primary Insurance Name	Id#	Group#

Insurance Address	Phone#

Policy Holder Name	Date of Birth

Policy Holder Employer	SS#

Secondary Insurance Name	Id#	Group#

Insurance Address	Phone#

Policy Holder Name	Date of Birth

Policy Holder Employer	SS#

I understand and agree that I am ultimately responsible for the balance of my account for any professional service rendered. I have completed ALL of the information on this sheet, and certify that the information is true and correct to the best of my knowledge. I will notify you of any changes in this information.

I hereby instruct and direct my insurance to pay Capitol Allergy and Asthma Center for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY. This payment will not exceed my debt obligation to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I also authorize the release of any information pertinent to my case to any professional involved in this case.

I give consent to Capitol Allergy and Asthma Center, for the purposes of use and disclosure of my individually identifiable health information(IIHI) for treatment, payment, and other health care operations(TPO), according to the Health Insurance Portability and Accountability Act of 1996(HIPAA).

I also agree to be responsible for any services performed by Capitol Allergy and Asthma Center considered non covered, co-insurance, contractual copayments, and my deductibles allowed by my insurance company.

Signature of Policy Holder/Guarantor/Guardian _____ Date _____

Print Name _____