Columbus
Grove City

ALLERGY & ASTHMA, Inc.

H.C.Nataraj, M.D.
614-864-2736 800-864-1077

Lancaster
Logan

REGISTRATION: *(Please print)*

Date: _____

Patient Name: _____ **SS#** _____

Sex: ___M ___F Age: _____ Birthdate: _____ ** *E-MAIL*_____ M ___ S ___ W ___

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Spouse name: _____ Birthdate: _____ Cell phone: _____ Work phone: _____

Family Physician: _____ Physician Phone: _____
Referring Physician: _____ Physician Phone: _____
Preferred Pharmacy: _____ Phone number: _____
Drug allergies: _____

MAY WE LEAVE A MESSAGE AT YOUR HOME WITH OTHER RESIDENTS? _____Y _____ N
MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? _____ y _____ N

RESPONSIBLE PARTY: *Relationship to patient >* *Self* _____ *Father*_____ *Mother*_____ *Other*_____

Name: _____ Birthdate: _____ SS# _____

Address: _____ City: _____ State: ____ Zip: _____

Home phone: _____ Work phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____ Relation to patient: _____

PRIMARY INSURANCE: ***

Primary Insurance: _____ Policy Holder Name: _____

Policy Id Number# _____ Policy Group Number # _____
Policy Holder SS# _____ Relationship to patient: _____ Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
Home phone: _____ Work phone: _____ Cell Phone: _____
Employer of policy holder: _____

SECONDARY INSURANCE: ***

Secondary Insurance: _____ Policy Holder Name: _____

Policy Id Number# _____ Policy Group Number # _____
Policy Holder SS# _____ Relationship to patient: _____ Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
Home phone: _____ Work phone: _____ Cell Phone: _____
Employer of policy holder: _____

****

Patient / Parent / Guardian Signature: _____ Date: _____