

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: _____