

Allergy, Asthma & Immunology Clinic of Colorado



William S. Silvers, M.D., P.C.

Pediatric Patient Information

Date _____

Patient's name _____ Sex: M F
(first) (middle) (last)

Address _____ City _____ State _____

Zip code _____ Home phone _____ Date of birth _____

Father's name _____ Mother's name _____

SS# _____ SS# _____

Address _____ Address _____

Employer _____ Employer _____

Business phone _____ Business phone _____

Whom may we thank for referring you to our office? _____

Who is your primary care physician? _____ Phone _____

Address _____

In case of emergency, please list a friend or relative living in the Denver area that we should contact:

Name _____ Daytime phone _____ Relationship _____

Insurance Company Information

Insurance company name _____

Effective date of policy _____ Group number _____

Name of HMO _____ Name of PPO _____

Claims phone _____ Co-payment amount _____

Claims address _____

Insurance Policyholder Information

Name of policyholder _____ SS# _____

Employer of policyholder _____

Please list all family members who see Dr. Silvers OR OTHER STAFF _____

<p>I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR THESE SERVICES AND ALL FUTURE CLAIMS.</p> <p><input checked="" type="checkbox"/> _____</p> <p>SIGNED BY PATIENT OR AUTHORIZED PERSON</p>	<p>I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.</p> <p><input checked="" type="checkbox"/> _____</p> <p>SIGNED BY PATIENT OR AUTHORIZED PERSON</p>
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TO OUR NEW PATIENT:

Due to the nature of the insurance industry, we are unable to guarantee that your policy will cover our charges, either partially or in full. We participate in many PPO and HMO groups but all charges are subject to your insurance policy's limitations, pre-existing condition clauses and referral requirements. **IF YOU DO NOT OBTAIN A REFERRAL FOR OUR SERVICES, YOU WILL BE RESPONSIBLE FOR ANY RESULTING BALANCES.**

If a staff member states that you are completely covered, or that you will owe nothing, or suggests anything about how your insurance will pay, please contact your insurance company for verification. Such statements are invalid and do not constitute grounds for non-payment of patient liabilities.

Your signature indicates that you understand the above paragraphs.

THANK YOU!

SIGNATURE _____

DATE _____

**All appointments
not cancelled 24 hours
prior to scheduled appt.
will be charged
\$35.00**