Allergy, Asthma & Immunology Clinic of Colorado

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

ADULT PATIENT INFORMATION

Date ____________________

Patient Name ____ Sex: M F
(First) (Middle) (Last)

Mailing Address ______________________________ City ______________ State __________

Zip Code __________ Home Phone ____________________ Date of Birth ______________

Personal Email: ______________________________ Cell Phone ____________________

Employer ______________________________ Position ____________________

Business Phone ______________________ SS# ____________________

Name of Person Responsible for bill ____

Spouse's Name ______________________ Employer ____________________

Position ______________________ 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 ____

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Insurance Policyholder Information

Name of Policyholder ______________________________ SS# ______________

Employer of Policyholder ____

Please list all family members who see our staff: ______________________________

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I authorize payment of medical benefits to undersigned physician or supplier for these services and all future claims. X ______________________________ Signed by Insured or Authorized Person	I authorize the release of any medical information necessary to process this claim and all future claims. X ______________________________ Signed by Insured or Authorized Person