



Suri R. Suresh, M.D.
Sridhar Guduri, M.D.

Board Certified
 Children & Adults
 www.ohioallergy.com

**ALL INFORMATION MUST BE COMPLETED IN ORDER FOR US
 TO FILE WITH YOUR INSURANCE COMPANY**

Patient Information	
Name (L, F, M)	Gender
Address	Date of Birth
City, State Zip.	Soc Sec #
Home Phone	Marital Status
Work Phone	

Responsible Party (Financial) / Employer Information	
Name (L, F, M)	DOB Soc Sec #
Address	Employer
City, State Zip.	Emp. Address
Home Phone	Emp. City, State Zip.
Work Phone	Relationship to patient

Insurance Information: Primary (if different from above)	
Policy Holder	Insurance Company
Relationship to Patient	Mailing Address
DOB Soc Sec #	City, State Zip
Is a referral required by your insurance? Yes No	Co-pay Amount Effective Date
Group #	Subscriber #

Insurance Information: Secondary	
Policy Holder	Insurance Company
Relationship to Patient	Mailing Address
DOB Soc Sec #	City, State Zip
Is a referral required by your insurance? Yes No	Co-pay Amount Effective Date
Group #	Subscriber #

DUBLIN	EAST COLUMBUS	WESTERVILLE	GROVE CITY	MANSFIELD	ZANESVILLE
(614) 760-0099 (tel)	(614) 864-8238 (tel)	(614) 895-6753 (tel)	(614) 539-3360 (tel)	(419) 526-2125 (tel)	(740) 455-6030 (tel)
(614) 734-0409 (fax)	(614) 751-9776 (fax)	(614) 895-7136 (fax)	(614) 539-5517 (fax)	(419) 522-0241 (fax)	(740) 454-3001 (fax)



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Primary Care Physician	
PCP Name	Referred By
Practice Name	Practice Name
Address	Address
City, State Zip	City, State Zip
Phone #	Phone #

Assignment and Release:

I authorize Allergy and Asthma Clinics of Ohio to release any information concerning my or my dependent's illness and treatment to insurance carriers. I authorize the release of medical records in response to a court order. I authorize substitution of a photocopy of this form in place of any original. I have read and understood the Notice to Privacy Practices presented to me, and any questions concerning it have been answered to my satisfaction.

I consent to and authorize the administration of treatment and procedures deemed necessary or advisable for the above named patient.

----- Date-----
 (Patient or authorized signature)

I certify that I (or my dependent) have insurance coverage and assign such coverage directly to Allergy and Asthma Clinics of Ohio all payments for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In addition, I am responsible for all co-pays, deductibles and referrals that are required by the insurance company. I authorize Allergy and Asthma Clinics of Ohio to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

----- Date-----
 (Patient or authorized signature)

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