ALLERGY, ASTHMA, & IMMUNOLOGY MEDICAL GROUP

PRASHANT VERMA, MD
SANJIV VERMA, MD
PREETI CHOPRA, MD

5720 RALSTON ST
SUITE 205
VENTURA, CA 93003
•
PHONE: 805-658-9500
FAX: 805-658-9501

451 W. GONZALES RD
SUITE 150
OXNARD, CA 93036
•
PHONE: 805-983-0771
FAX: 805-983-6139

4000 CALLE TECATE
SUITE 112
CAMARILLO, CA 93012
•
PHONE: 805-419-5570
FAX: 805-658-9501

23928 LYONS AVE
SUITE 201
NEW HALL, CA 91321
•
PHONE: 661-388-0588
FAX: 805-658-9501

Welcome to our office !!

INSTRUCTIONS FOR FILLING OUT THIS PACKET:

• This document contains the following items:

1. Registration Form = 1 page
2. New Patient Questionnaire (your medical history) = 4 pages
3. HIPAA Notice of Privacy Policy = 1 page
4. Consent to treatment, Acknowledgement Form = 1 page
5. Medical Records Release Form = 1 page

• Please complete ALL forms.

• It will take ***approximately 30 minutes*** to fill out these forms. By completing them at home, you will save time at your appointment.

• In the questionnaire, not all the questions will be related to your medical condition. If it is not applicable for you, disregard it and move to the next question.

• If you are not sure about a question, skip it. The doctor will go through these questions and any relevant medical history with you at your first appointment.

• After you have completed the forms, be sure to ***bring them with you to your first appointment.***

CHECKLIST OF THINGS TO BRING TO YOUR APPOINTMENT:

[ ] Insurance Card (Bring the ***actual*** insurance card – no pictures or copies)
[ ] Government issued photo ID / Driver's License (the ***actual*** ID)
[ ] The ENTIRE set of new patient paperwork in this packet
[ ] List of prescriptions, herbs, vitamins, over-the-counter medications
[ ] Co-pays
[ ] Any prior authorization paperwork you may have
[ ] Physician referral forms (if necessary)
[ ] Recent Allergy tests, X-rays, CAT scans, PFTs (if available)

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REGISTRATION FORM

DEMOGRAPHIC INFORMATION

PATIENT NAME_____ Nick Name_____ Date _____

Birth date_____ Age ____ Sex ____ Social Security#._____Driver's License# _____

Home Address _____City/Zip_____

Work Address_____City/Zip_____

Our Office Sends Text and Email reminders for appointments

Cell # _____ [ ] I can [ ] I cannot RECEIVE TEXT MSGS

Email _____ [ ] I can [ ] I cannot RECEIVE EMAILS

Home # _____Work #_____

INSURANCE INFORMATION

PRIMARY INSURANCE _____EFFECTIVE DATE _____

POLICY # _____ INSURANCE GROUP # _____

POLICY HOLDER INFO: Name: _____ Phone: _____

*Relationship to patient_____ Date of Birth: _____ Driver's License#:_____

*Social Security # _____Address_____

SECONDARY INSURANCE _____EFFECTIVE DATE _____

POLICY # _____ INSURANCE GROUP # _____

TERTIARY INSURANCE _____EFFECTIVE DATE _____

POLICY # _____ INSURANCE GROUP # _____

OTHER INFORMATION

PRIMARY CARE PROVIDER _____ Phone_____ Fax _____
(first and last name)

Referring Provider (if different) _____ Phone _____ Fax_____
(first and last name)

Emergency Contact: _____Relationship: _____Phone_____

FEDERAL GOVERNMENT REQUIRED QUESTIONS

Patient Race (circle): Afr American Asian Caucasian Hispanic Pac. Islander Native American Other _____

PREFERRED LANGUAGE: [ ] English [ ] Spanish [ ] Other _____

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NEW PATIENT QUESTIONNAIRE

DEMOGRAPHIC INFORMATION

PATIENT NAME_____ Nick Name_____ DATE _____

Birth date_____ Age ____ Sex ____ Cell # _____ Email _____

Home Address _____ City _____

Current Occupation _____ Relevant Previous Occupations _____

Exposure to allergens at work (currently or previously)? _____

Primary Care Provider _____Phone_____Fax _____
(first and last name)

Referring Provider (if different) _____Phone _____Fax_____
(first and last name)

Type of Insurance (circle): HMO PPO TRICARE/TRIWEST/VA MEDICARE MEDI/MEDI CASH PAY

PHARMACY INFORMATION

Local Retail Pharmacy Name: _____ Cross Streets _____ Phone _____

Mail Order Pharmacy Name: Fax

LIST THE REASONS FOR YOUR VISIT TODAY (CHIEF COMPLAINTS):

* I already saw (name/specialty) for this problem _____

1. _____Since When _____

2. _____Since When _____

3. _____Since When _____

List All Present Medications / Supplements / Herbs that you use *DAILY or AS NEEDED:*

Name of the Drug*Dose***************Any Relief*********Any Side Effects****Taking Since**

_____

_____

_____

_____

_____

_____

_____

_____

HISTORY OF PRESENT ILLNESS AND REVIEW OF SYSTEMS (Circle , Fill in blanks)

Do symptoms affect your life? Disturbed sleep Fatigued Affects work Affects school Can't do activities _____

Nose / Sinuses: Itchy nose Sneezing Stuffy nose Mouth Breathing Runny Nose Nasal drip ___clear ___ colored
Snoring Nasal polyps Nose bleeds Sinus Pressure Sinus Headaches Sinus infections: ___ per year
Triggers: Dust Pollen Mold Smog Animals East Winds Weather Yard work Cold air A/C
Odors/Chemicals Smoke Indoors Outdoors Seasons: spring / summer / fall / Year around
MEDS THAT HELP? _____ ENT SURGERIES: _____

Throat: Post nasal drip Throat clearing Hoarseness Itchy throat Choking/Difficulty Swallowing
Eosinophilic Esophagitis _____Diagnosed when?_____Doctor/Treatment_____
Tonsillectomy? Adenoidectomy?____When/What Age? _____ Surgeon? _____

Ears: Ear popping Itchy ears Hearing loss Plugged ears Infections_____per year PE Tubes placed_____

Eyes: Itchy Watery Swelling Redness Dark circles Pus **MEDS THAT HELP?** _____

Chest/Lungs: Cough: Dry / Productive / at night / all day Phlegm: Clear / Colored / Blood streaked Shortness of breath

Wheezing : Day / Night / with Exercise Chest congestion Chest tightness Chronic Bronchitis

Asthma diagnosis [ ] no [ ] yes: since when? _____ meds tried? _____

Asthma triggers: Getting sick Exercise Nighttime Cold air Animals Weather East Winds Smog
Dust Pollen(grass,trees,weeds) Smoke Strong smells (perfume/cologone/chemicals, etc)

Asthma severity: # of visits to the ER/urgent care in the last 12 months _____ most recent____ _____
# of oral/ injected steroid treatments (i.e. Prednisone) in the last year _____ most recent _____
# of emergency visits to primary care in the last 12 months for asthma _____most recent_____
# of DAYS IN THE HOSPITAL in the last 12 months for asthma _____
# of DAYS MISSED of school or work in the last 12 months for asthma _____
Can you do all your normal activities and exercise with your asthma? [ ] No [ ] Yes

Skin (circle) **Eczema:** Since when _____ Sites involved: Neck Arms Back of Knees Other _____

Rash / Hives / Swelling: Since when_____ How often _____ Triggers _____

Location on body _____ Meds tried _____

Contact Allergy Rash: Jewelry / Cosmetics / Soaps / Poison Ivy-Oak / Latex (rubber) / Other _____

Itchy Skin: [ ] All over body [ ] Certain parts _____

Abdominal: GERD(heartburn/reflux) Foods that cause GERD _____ Meds used _____

Nausea Pain/Cramps Gas Vomiting Constipation Diarrhea Bloody stool

Elimination Diets? [ ] No [ ] Yes: _____How Long? _____ Improvement? ___

Immune Deficiency Screening: Do you suffer from recurrent infections? [ ] No [ ] Yes…since when _____
Vaccine History: [ ] I am up to date with all my vaccines [ ] I am not up to date [ ] I am not sure
Infections: [ ] Chronic sinusitis/bronchitis: How many _____ # treated with antibiotics per year _____
[ ] Bacterial Pneumonia: How many _____ # treated with antibiotics per year _____
[ ] Skin infections/boils: How many _____ # treated with antibiotics per year _____
[ ] Internal infections: How many _____ What types: _____
[ ] Recurrent Ear Infections: How many _____ # treated with antibiotics per year _____
Any cultures growing specific organisms? _____

PAST HISTORY

FOOD ALLERGY/INTOLERANCE **DRUG ALLERGY/INTOLERANCE**

******Which FOOD****Reaction Felt *********When it First Occurred**** *****Which DRUG********Reaction Felt******When it First Occurred****

1_____ ***1**_____

2_____ ***2**_____

3_____ ***3**_____

4_____ ***4**_____

INSECT STING REACTIONS: Never Stung Stung: Once / Frequently Stinger left behind / No stinger

What Stung You_____Where on your body__ _____Date of First & Last Sting _____

Describe Reaction to sting: Local Reaction _____ Anaphylactic Reaction _____Did you goto hospital/Treatment received_____

IMMUNIZATION HISTORY: Flu Shot [ ] No [ ] Yes…**When** _____ Pneumonia Shot [ ] No [ ] Yes…**When** _____

Other Vaccines (what/when): _____

PAST ALLERGY WORKUP AND TREATMENT:

[ ] Never tested [ ] Never seen an Allergy Doctor
[ ] Tested (when/where)_____ [ ] Blood test for allergies [ ] Skin test for allergies
Provider who did the test (Name/Specialty) _____
Results of the tests: _____
[ ] I had allergy immunotherapy (allergy injections)….when/how long _____Any relief?_____
Provider who gave allergy injections (Name/Specialty) _____

RECENT IMAGING (circle) : Chest XRAY / Chest CT / Sinus CT…..results? _____

PAST MEDICAL HISTORY: (circle any) Milk/Formula Intolerance Infantile Colic Eczema Diaper Rash Thrush Psoriasis Bronchiolitis Asthma Bronchitis Pneumonia Emphysema Thyroid Problems Diabetes High blood pressure High Cholesterol Heart Problems Heart attack Kidney Problems Prostate Enlargement Arthritis Glaucoma Migraine ENT Surgeries IBS Lupus Rheumatoid Arthritis TB Valley Fever Cocci Histo HIV AIDS Mono Hepatitis A / B / C GERD IBD Cancer_____Other:_____

HOSPITALIZATION HISTORY (list when/why): _____

PAST SURGICAL HISTORY (list): _____

BIRTH HISTORY (for children): Born full term ____ Normal Delivery ____ C-Section ____ Premature _____No perinatal problems
Nursed (Breast Fed): No_____ Yes_____ How long _____ Respiratory Distress at birth ____Jaundice needing treatment at birth ____Newborn Sepsis
Problems with Reg. Formula ____ Problems with Soy Formula ____Problems with baby food_____ Other: _____

FAMILY HISTORY: [ ] I have a family history of allergies [ ] I DO NOT have a family history of allergies
__Relation_____Illness(include Allergies / Sinus Conditions / Asthma / Emphysema)_____Since When_____Present Treatment _____
__Father _____
__Mother _____
__Brother _____
__Brother _____
__Sister _____
__Sister _____
__Daughter _____
__Daughter _____
__Son _____
__Son _____

ENVIRONMENTAL AND SOCIAL HISTORY

Where do you live? [ ] Urban/City [ ] Suburbs [ ] Rural/Farm/Ranch **Type of home?** [ ] Apartment [ ] House [ ] Mobile Home

Basement: [ ] No [ ] Yes __ Is it [ ] Damp or [ ] Dry S**mokers at home?** [ ] Yes [ ] No

Air Conditioner: [ ] Central [ ] Window Unit [ ] Humidifier [ ] Dehumidifier [ ] None [ ] Other _____

Heating System: [ ] Central Air/Forced Air [ ] Radiator [ ] Space Heater [ ] Fireplace [ ] None

Type of Floors: Living Area [ ] Carpet [ ] Wood [ ] Vinyl [ ] Other _____

Bedroom**:** [ ] Carpet [ ] Wood [ ] Vinyl [ ] Other _____

Type of Bed: [ ] Water bed [ ] Regular bed [ ] Bunk bed

Do you have dust mite encasings/covers for the Mattress? [ ] Yes [ ] No

Box spring? [ ] Yes [ ] No

Type of Pillows: [ ] Feather [ ] Polyester [ ] Foam [ ] Cotton

Do you have dust mite encasings/covers for the Pillows? [ ] Yes [ ] No

Pets: [ ] None [ ] Dogs [ ] Cats [ ] Birds [ ] Other _____

[ ] How Many? _____

Are they: [ ] Outdoor [ ] Indoor [ ] In the bedroom

[ ] Describe any allergy symptoms around your pets _____

Stuffed Animals / Plush Toys: Are they in the bedroom ? [ ] Yes [ ] No

Air Filters: [ ] I don't have one [ ] I have one and use it in the following rooms: _____

Hobbies: Yours _____

Any allergic reactions seen_____

Hobbies of Family members that affect your allergies _____

Social: Do you or Did You Smoke _____ What _____

Age when started? _____ For How Many Yrs.? _____ Age when quit? _____

Any other smokers at home? [ ] No [ ] Yes…..Who_____ Indoors _____ Outdoors_____

Do you drink? _____ Social Drinking? ____ Have drinking problems? _____ Any history of drug use? _____

OTHER INFORMATION: Write any other information you think might be important.

_____

_____

_____

_____

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Notice of Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the health care professional has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights -- The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints -- You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. **We will not retaliate against you for filing a complaint.**

This Notice is effective as of **April 15, 2003.**

Privacy Officer: Allergy, Asthma, and Immunology Medical Group
Attention: Gabriela Perez
5720 Ralston Street, Suite 205
Ventura, CA. 93003
(805) 658 – 9500

We Take Care of the Whole Family

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General Consent for Treatment, Release of Information, Insurance Coverage Policy, And Acknowledgment of receipt of The Notice of Privacy Policy

1. **Consent:** I hereby voluntarily request, consent to, and authorize ALLERGY ASTHMA AND IMMUNOLOGY MEDICAL GROUP and its staff to provide medical care including the administration of medications as deemed necessary and advisable.
2. **Release of Information:** I hereby authorize ALLERGY ASTHMA AND IMMUNOLOGY MEDICAL GROUP to release to any third party payer, or its representative, which may be responsible for payment in my case, or as required by law, such information from my patient records as is necessary in order to receive reimbursement for any services rendered relating to my treatment.
3. **Physician Referral:** I understand that if my health insurance is provided by a managed care plan, I am responsible for contacting my primary care physician and obtaining necessary referrals for any services rendered at this office. Failure to do so will result in my being financially responsible for said services.
4. **Payment:** I understand that I am responsible for any health insurance deductibles and/or co-payments. I understand that I am financially responsible for the cost of services at the time they are rendered unless prior arrangements have been made. I understand that if my medical plan denies payment of services, I will be responsible for payment of said services.
5. **Accuracy & Integrity:** I hereby acknowledge the information I provided on the patient information form and patient history to be true and correct and completed to the best of my ability.
6. **Treating Providers:** ALLERGY ASTHMA AND IMMUNOLOGY MEDICAL GROUP reserves the right, at all times, to designate the licensed provider who will perform any medical services requested of it, irrespective of whether or not the licensed provider so designated is an employee of this corporation.
7. **No Guarantees:** I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees are made as to the result of the care and treatment which I have hereby authorized.
8. **Contact:** I understand that ALLERGY ASTHMA AND IMMUNOLOGY MEDICAL GROUP may contact me through any of the following methods for reminders about appointments, statements, insurance coverage, etc: Phone call, Text message, Email, Letter by mail, or through the Patient portal.
9. **Child Treatment Authorization (optional)**:

   [ ] I authorize ALLERGY ASTHMA AND IMMUNOLOGY MEDICAL GROUP to examine and/or treat my child (less than 18 years old) in my absences, while accompanied by someone appointed by me, the parent or legal guardian of the child.

I have read this form or it has been read to me and I am satisfied that I understand the entire contents and significance of this form, and all my questions (if any) have been answered. Further, I understand that this consent will be deemed continuing and I am free to revoke my consent at any time.

I also acknowledge that I have read and received a copy of The Notice of Privacy Policy. I understand that ALLERGY ASTHMA AND IMMUNOLOGY MEDICAL GROUP may refuse to evaluate and treat me if I do not consent to the use or disclosure of my health information as detailed in The Notice of Privacy Policy

_____

Patient Name (PRINT) Date of Birth

_____

Patient or Parent/Legal Guardian Signature Today's Date

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REQUEST FOR MEDICAL RECORDS RELEASE

Patient Name: _____

DOB: _____

A mutual patient has come to our office for treatment.
Please send any of the following records that you feel pertinent to our workup.

1. Recent Progress Notes
2. Allergy test results
3. Laboratory results
4. Imaging Results
5. Pulmonary Function Tests
6. Other

_____

Kind personal regards,

Prashant Verma, M.D.
Sanjiv Verma, M.D.
Preeti Chopra, M.D.

_____

Patient/Parent/Legal Guardian Signature

_____

Witness