Connecticut Advanced Spine, LLC
Ashish Upadhyay, M.D.

Name:____________________ Age: ____________ Today's date:________________

Date of Birth:________________ Marital Status:________________ Gender: M / F SSN:________________________

Address: ____________________________________ City/State________________ Zip ____________

Primary Phone #: ____________________ Cell #: ____________________ Work #: ____________________

Email Address:____

Employer:____________________________________ Occupation:________________________

Parent/Spouse____________________________________ Phone:________________________

Emergency Contact name/phone #:____

Pharmacy:________________________ City/State:____________________ Phone:________________

Family Doctor's Name:____________________ Address:____________________ Phone #____________

Referring Doctor's Name:____________________ Address:____________________ Phone#____________

CIRCLE ONE**: Injured on the job?** Yes or No Date of injury:__________ **Auto Accident?** Yes or No Date of accident__________

INSURANCE INFORMATION **(PLEASE GIVE RECEPTIONIST INSURANCE CARDS FOR COPYING)**

Primary Health Insurance:______________________________ ID#:________________ Group #:______________

Address:______________________________ City/State: ________________ Zip:________________

Insured's Name:______________________________ DOB:____________ Employer:____________________

Secondary Health Insurance:______________________________ ID#:________________ Group #:______________

Address:______________________________ City/State: ________________ Zip:________________

Insured's Name:__________________________ DOB:____________ Employer:________________________

Workers Comp/Auto Insurance:____________________________________ Claim #:________________________

Claims Adjustor:________________________ Phone #________________ Date of Injury:________________

Employer (where your injury occurred): ____

I VERIFY THAT THE INFORMATION LISTED ABOVE IS COMPLETE AND ACCURATE TO DATE. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ANY AND ALL CHARGES RESULTING FROM FAILURE TO DISCLOSE ACCURATE, COMPLETE AND CURRENT INSURANCE COVERAGE INFORMATION. THE GUATANTOR UNDERSTANDS ALL PATIENTS ARE PERSONALLY RESPONSIBLE FOR ANY BALANCES REMAINING AFTER THE INSURANCE COMPANY HAS MADE PAYMENT. I HERBY ASSIGN AND DIRECT PAYMENT OF MEDICAL BENEFITS TO CONNECTICUT ADVANCED SPINE, LLC IN THE EVENT OUR PHYSICIAN AND/OR APRN ARE NOT PARTICIPATING WITH MY INSURANCE PLAN AND I RECEIVE PAYMENT DIRECTLY FROM MY INSURANCE COMPANY, I AGREE TO ENDORSE ANY PAYMENT DIRECTLY TO THIS OFFICE.

SIGNATURE: ____ DATE:________________________

I HEREBY AUTHORIZE CONNECTICUT ADVANCED SPINE, LLC TO FURNISH INFORMATION TO MY INSURANCE CARRIER(S), ATTORNEY(S), PHYSICIAN(S) PHYSICAL THERAPIST(S), REHAB CONSULTANT(S) CONCERNING MY TREATMENT. I ALSO AUTHORIZE MY INSURANCE CARRIER(S), ATTORNEY(S), PHYSICIAN(S) PHYSICAL THERAPIST(S) AND/OR REHAB CONSULTANT(S) TO RELEASE ANY INFORMATION NEEDED DIRECTLY TO CONNECTICUT ADVANCED SPINE, LLC.

SIGNATURE: ____ DATE:________________________