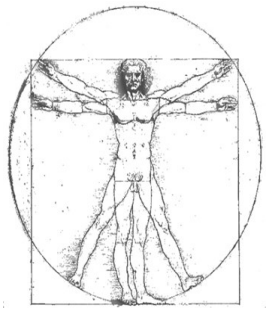

Bardia Asgari, MD
Primary Care of Shelton, LLC
Tel: 203 225 0506
Fax: 203 225 0592
Email: bardia.asgari@pcofshelton.org

Last Name: _____ M: __ First Name: _____

Street: _____ City: _____

State: ____ Zip Code: _____ Email address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Emergency Contact: _____

Birth Date: _____ Sex/Gender: M __ F __ other ___

Social Security: _____ Marital Status: M_ S_ D_ SEP_ W

Insurance Company: _____

Policy Holder: _____ Relationship to insured: _____

Policy Number: _____ Group Number: _____

I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and, subject to the following restriction(s) concerning my personal medical information, I agree to the disclosures in the Notice. I also understand and agree to being charged up to $30.00 for a missed regular appointment or 50$ for a physical exam (given longer time allocation) as well as the $35.00 charge for any returned check. I agree that by signing
this form authorizes Primary Care of Shelton to bill to my insurance company.

Patient's Signature: _____ Date: __/__/____

Legal Guardian's Signature: _____ Date: __/__/_____