



✓ Check all that apply: NEW PATIENT UPDATE PRIVATE INSURANCE HMO PPO MEDICARE MEDICAID

PATIENT INFORMATION - PLEASE PRINT CLEARLY

PATIENT NAME LAST		FIRST		MI	DATE OF BIRTH M / D / Y	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY #	
PHONE ()		MAILING ADDRESS			CITY		STATE	ZIP CODE
MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widow/er		SPOUSE NAME			PATIENT OCCUPATION			
EMPLOYER PHONE ()		EMPLOYER NAME & ADDRESS			CITY		STATE	ZIP CODE
IN CASE OF EMERGENCY NOTIFY (Other than responsible party or spouse)					RELATIONSHIP <input type="checkbox"/> Relative <input type="checkbox"/> Friend		PHONE NO. ()	

REFERRAL INFORMATION

REFERRAL SOURCE: <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Friend <input type="checkbox"/> Relative <input type="checkbox"/> Other			NAME OF REFERRING FRIEND/RELATIVE			PHONE #		
NAME OF FAMILY DOCTOR/PRIMARY CARE PHYSICIAN		CITY	NAME OF REFERRING DOCTOR OR HOSPITAL		CITY	DATE OF LAST VISIT M / Y		

OTHER FAMILY MEMBERS SEEN:

RESPONSIBLE PARTY (If same as patient, leave blank)

RESPONSIBLE PARTY NAME LAST		FIRST		MI	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP TO PATIENT: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other
PHONE ()		STREET ADDRESS			CITY		STATE	ZIP CODE
EMPLOYER PHONE NO. ()		EMPLOYER NAME & ADDRESS				OCCUPATION		

IF PATIENT IS A STUDENT OR A MINOR, PLEASE GIVE THE FOLLOWING INFORMATION

FATHER'S NAME (If not listed as responsible party)		MOTHER'S NAME (If not listed as responsible party)	
ADDRESS (If different than patient)		ADDRESS (If different than patient)	
HOME PHONE ()	WORK PHONE ()	HOME PHONE ()	WORK PHONE ()

CONSENT FOR TREATMENT

I hereby request and permit the Allergy & Asthma physicians to render to the above-named patient any medical/surgical treatment he/she may require in my absence.

SIGNATURE OF PARENT OR GUARDIAN

RELATIONSHIP

DATE SIGNED

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME		GROUP NO. OR NAME	INSURED'S I.D. # /SOC. SEC. #	INSURED'S Last / First Name	
INSURANCE CO. ADDRESS		CITY	STATE	ZIP	INSURED'S D.O.B.
					INSURANCE CO. PHONE NO.

SECONDARY INSURANCE COMPANY

INSURANCE CO. NAME		GROUP NO. OR NAME	INSURED'S I.D. # /SOC. SEC. #	INSURED'S Last / First Name	
INSURANCE CO. ADDRESS		CITY	STATE	ZIP	INSURED'S D.O.B.
					INSURANCE CO. PHONE NO.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Allergy & Asthma Center, P.C. and my insurance company to exchange any information which either party may request concerning my claim. I furthermore assign to Allergy & Asthma Center, P.C. all insurance payments relative to the services performed.

X

SIGNATURE OF RESPONSIBLE PARTY

DATE SIGNED