Allergy & Asthma Center, P.C.
Eugene - (541) 485-0316

PATIENT REGISTRATION

DATE ___/___/___

✓ 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 ❑ M ❑ F	SOCIAL SECURITY #

PHONE ( )	MAILING ADDRESS	CITY	STATE	ZIP CODE

MARITAL STATUS ❑ Married ❑ Divorced ❑ Single ❑ 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 ❑ Relative ❑ Friend	PHONE NO. ( )

REFERRAL INFORMATION

REFERRAL SOURCE: ❑ Yellow Pages ❑ Physician ❑ Hospital ❑ Friend ❑ Relative ❑ 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 ❑ Male ❑ Female	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP TO PATIENT: ❑ Parent ❑ Spouse ❑ 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