ALLERGY & ASTHMA
CLINIC

Welcome!

Patient Information

Date: Soc. Sec. #: Birth Date:

Name:

Last Name First Name Initial

Address: Home Phone:

City: State: Zip:

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer: Business Phone:

Business Address: Occupation:

Whom may we thank for referring you?

In case of emergency, who should we contact? Phone:

Primary Insurance

Person Responsible for Account:

Last Name First Name Initial

Relationship to Patient: Birth Date: Soc. Sec. #:

Address: Home Phone:

City: State: Zip:

Responsible Party Employed By: Business Phone:

Business Address: Occupation:

Insurance Company:

Insurance Company Address:

Subscriber I.D. #: Group #:

Additional Insurance

Insured Name:

Last Name First Name Initial

Relationship to Patient: Birth Date: Soc. Sec. #:

Address: Home Phone:

City: State: Zip:

Insured Employed By: Business Phone:

Insurance Company:

Insurance Company Address:

Subscriber I.D. #: Group #:

Assignment and Release

I hereby authorize payment directly to Dr.__________________ of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party Date: