THE ALLERGY & ASTHMA CENTER, P.C.

Date_____ How did you hear of our office?_____

I. Please complete the following information about the PATIENT:

_____ Age _____
Patient Last Name First Name Middle Name Suffix (Jr, Sr, etc)

Home Address _____ City _____
State _____ Zip_____ Birth date: ____/____/____ Sex: M _____ F _____
Social Security # _____/____/_____ Drivers License # _____ State _____
Home Phone _____ Work Phone _____ Cell Phone _____
Patient regular doctor or pediatrician _____
Marital Status: Married ____ Single ____ Divorced ____ Widowed ____
Employment Status: ___employed ___self employed ___unemployed
___full time student ___part time student ___retired
Race: ____Am Indian ____Asian ____Black ____Caucasian
Ethnicity: ____Hispanic ____non Hispanic ____declined
Language: ____English ____Spanish ____other _____
Patient Employer and Address_____
Occupation: _____

If patient is a minor, please provide:
Mother's Name_____ Mother's Daytime Phone _____
Father's Name _____ Father's Daytime Phone _____

II. Please complete the following information about the PRIMARY INSURANCE POLICY HOLDER:

Primary Insurance Co._____ Policy Holder's Name _____
Group Number: _____ Subscriber ID: _____
Policy Holder's Address: Street _____
City _____ State _____ Zip _____
Policyholder Social Security # ____/____/_____ Relationship to patient: _____ Phone_____
Date of Birth _____/____/_____ Sex: M _____ F _____
Employer Name _____ Full Time_____ Part Time_____
Employer Address _____ Work Telephone _____
Married _____ Single_____ Divorced_____ Widowed_____
Race: ____Am Indian ____Asian ____Black ____Caucasian
Ethnicity: ____Hispanic ____non Hispanic ____declined

III. Please complete the following if you have a SECONDARY INSURANCE POLICY:

Secondary Insurance Co._____ Secondary Policy Holder Name_____
Secondary Policy Holder Address_____
City_____ State _____ Zip_____ Social Security # ____/____/_____
Home Phone _____ Date of Birth _____/____/_____ Sex: M _____ F ____
Employer Name_____ Full time_____ Part time _____
Employer Address _____ Work Phone _____
Married _____ Single_____ Divorced_____ Widowed _____

IV. Emergency Contact Information
Person to notify in event of emergency (list someone other than those listed above):

Name _____ Relationship to patient_____
Address _____ Phone _____
City _____ State _____ Zip _____

V. Please complete the following information *if someone other than the patient or policy holder is responsible* for paying the charges.

Responsible Party:

Name _____
Last First Middle

Address _____ City _____ State _____ Zip _____
Home Phone _____ Date of Birth ____/____/_____ Sex: M ____ F ____

Relationship to patient: Spouse_____ Parent_____ Guardian_____ Other _____

Social Security # _____ Driver's License # _____ State _____
Employer _____ Work Phone # _____

VI. Please read and initial the following paragraphs:

_____ Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

_____ If this account is placed for collections and/or legal suit, the practice shall be entitled to collections costs, attorney and legal fees.

_____ I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the Allergy & Asthma Center, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

VII. PERSONAL MEDICAL INFORMATION

May we leave personal medical information on your answering machine at home? Yes No
May we leave personal medical information on your answering machine at work? Yes No

May we email you? Yes No Email address_____
May we text you? Yes No Cell phone _____

By signing this consent, I indicate that I understand that email and text messages are not secure. I will not hold the practice or any of its employees liable for any loss of confidentiality associated with information transmitted by email or text message. I understand that email and text messages are not encrypted and therefore not secure. _____ Initial

I authorize the practice to release or request any of my personal health information in order to carry out treatment, to determine liability for payment, or to obtain reimbursement on any claims. _____ Initial

Do you give us permission to discuss personal medical information with family members? Yes No
If yes, list name(s) of person(s) authorized:

_____ Relationship: _____ Phone: _____
_____ Relationship: _____ Phone: _____

WE REQUEST THAT INSURANCE CO-PAYMENTS AND/OR DEDUCTIBLES BE PAID AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE PRIOR TO SERVICE. THANK YOU.

HOW WILL YOU BE PAYING TODAY? CASH___ CHECK___ VISA___ MASTERCARD___ DISCOVER___

_____ DATE _____
Signature (Patient, or parent/legal guardian if patient is a minor)

_____
Print Name