Update/Change _____ New _____

Office Use: Patient # _____ Facility: Doctor: _____

ASSOCIATED ALLERGISTS AND ASTHMA SPECIALISTS, LTD.

THIS FORM MUST BE COMPLETED IN FULL.
PLEASE PRESENT INSURANCE CARD FOR COPYING AND REMIT COPAY (IF APPLICABLE)

PATIENT INFORMATION – PLEASE PRINT **DATE:_____**

Name (full given name): _____

Address: _____

City, State & Zip Code: _____

Home Phone# (with area code)_____ Cell Phone # (with area code) _____

Social Security # _____ Birthdate: _____ Age:_____ Sex: M F

Status: (please circle) Minor Student Single Married Divorced Widowed Separated

Employer: _____ Work #: _____ Occupation _____

Employer Address, City, State & Zip: _____

If under 18: Mother's Name & Work/cell # _____ Father's Name & Work/cell#: _____

Family email address: _____

Emergency Name & Phone #: _____ Relationship: _____
(name & number of relative/friend that does not live at above address) *****REQUIRED*****

RESPONSIBLE PARTY (if patient is a minor, who brought the patient into the office to see the doctor)

Name: _____ Address: _____
(if different from patient)
Phone # _____ Date of Birth: _____ Relationship to patient: _____

PRIMARY INSURANCE INFORMATION

Name of Policy Holder: _____ Relationship to patient: _____

Birthdate: _____ Social Security # _____

Home address, City, State & Zip: _____
(if different from above)
Home Phone# _____ Cell Phone _____Occupation _____

Name of Employer: _____ Phone # _____

Address, City, State & Zip: _____

Medical Insurance Company Name: _____ eff.date_____

Type of Policy (circle) PPO HMO* POS* SELF-PAY MEDICARE PUBLIC AID OTHER

Does your policy require a copay? Y or N How much is your specialist copay? _____

*** If your insurance is an HMO or POS, a referral may be required to see the doctor. If you do not have a referral, you will be required to pay for the office visit. Obtaining a referral is the patient responsibility, we cannot call your doctor to request a referral, nor can we accept a referral after the date of service. Please call your insurance company if you are unsure if a referral is required.**

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REFERRING DOCTOR INFORMATION

Primary Care Doctor (name, not practice)_____ Phone # _____

Address, City, State & Zip : _____

Referring Physician:(If different from above)_____Phone # _____

Address, City, State & Zip: _____

REFERRAL INFORMATION (if applicable)

Auth # _____ # of visits authorized _____ Doctor authorized_____

Valid from_____ to _____

We do require a copy of the referral at the time of visit.

If you weren't referred by a doctor, where did you hear about us? _____

SECONDARY INSURANCE INFORMATION

Name of Policy Holder: _____ Relationship to patient: _____

Birthdate: _____ Social Security _____

Home address, City, State & Zip: _____
(if different from above)
Home Phone # _____ Cell Phone # _____ Occupation _____

Name of Employer: _____ Phone # _____

Address, City, State & Zip: _____

Medical Insurance Company Name: _____ eff. date: _____

Type of Policy (circle) PPO HMO POS SELF-PAY MEDICARE PUBLIC AID OTHER

Does your policy require a copay? Y or N How much is your specialist copay? _____

Are there other immediate family members with the same insurance information that are patients here? (please list names, birthdates, and relationship to the insured: _____

ON THE DAY OF SERVICE, ALL SELF-PAY PATIENTS ARE RESPONSIBLE FOR ALL FEES. PPO AND HMO PATIENTS ARE RESPONSIBLE FOR ALL COPAYS. PLEASE REMEMBER, YOU ARE RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

I authorize release of any medical information necessary to process this claim. I authorize payment of medical benefits to Associated Allergists & Asthma Specialists, Ltd. I hereby consent to allergy evaluation/treatment for the above named patient.

_____ _____ _____
Signature Date Relationship to Patient