



ALLERGY ASTHMA CARE, P.C.

PATIENT INFORMATION:

NAME _____ DOB ____/____/____ SEX: M__ F__

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY # ____-____-____ PHONE # ____-____-____ CELL PHONE# ____-____-____

EMAIL _____

EMPLOYER _____ PHONE # ____-____-____

SPOUSES'S NAME IF APPLICABLE _____

REFERRING DR. _____ PRIMARY CARE DR. _____

INSURANCE INFORMATION:

COMPANY _____ EFFECTIVE DATE _____

POLICY ID # _____ GROUP # _____ CO-PAY _____

POLICY HOLDER'S NAME _____ DOB ____/____/____

ADDRESS _____ PHONE # ____-____-____

EMPLOYER _____ PATIENT'S RELATIONSHIP TO INSURED _____

SECONDARY INSURANCE INFORMATION:

COMPANY _____ ID NUMBER _____

POLICY HOLDERS NAME _____ SOCIAL SECURITY # ____-____-____

ADDRESS _____ PHONE # ____-____-____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____

HOME PHONE # ____-____-____ WORK PHONE # ____-____-____ CELL # ____-____-____

BY MY SIGNATURE BELOW, I:

(A) authorize payment directly to Allergy Asthma Care, P.C., for the surgical and/or medical benefits, if any otherwise payable to me for the services; and

(B) authorize to release information acquired in the course of my examination or treatment to referring physician or my insurance company.

(C) have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

NAME _____ DATE _____

SIGNATURE _____