IDAHO ALLERGY AND ASTHMA CLINIC

PLEASE PRINT IN BLACK OR BLUE INK ONLY

Patient Information

Date _____

Name _____ Date of Birth _____ Parent or Gardian if Minor _____
Last Name First Name Middle Initial

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Address _____

City _____ State _____ Zip _____ Sex ☐ M ☐ F Age _____

Patient or Guardian Email: _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Divorced

Patient Employer _____ Race _____ Language _____ Ethnicity ☐ Hispanic ☐ Non-Hispanic

Spouse or Parent's Names _____ Advanced Directive ☐ Yes ☐ No

In case of emergency who should be notified? _____ Relationship _____ Phone (____) _____

Primary Insurance

Person Financially Responsible for Account (if other than Patient) _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Phone (____) _____

Insurance Company _____

Subscriber # _____ Group # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____

Subscriber # _____ Group # _____

Names of other dependents covered under this plan _____

(Signature Required)

Assignment and Release

If patient is a minor (under 18 years of age) I authorize _____ to act in my behalf to make decisions for my child's personal care, health care and procedures.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and **assign directly to IDAHO ALLERGY AND ASTHMA CLINIC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I authorize the use of my signature on all insurance submissions.**

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

(Signature Required)

Terms and Conditions

1. I agree to pay at the time of service, unless arrangements have been made in advance with our accounting department.
2. I agree that my/my dependent medical records can be released to referring/personal physician or for billing.

All information provided is accurate to the best of my ability. I/we have read and understand the above terms and conditions. I/we agree to pay all collection costs and/or reasonable attorney fees if any delinquent balance is placed with an agency or attorney for collection or suit.

Signature _____ Date _____