

ASSOCIATED ALLERGISTS AND ASTHMA SPECIALISTS, LTD.

PATIENT INFORMATION - PLEASE PRINT

Date: _____

Name (full given name): _____

Preferred Name/ Nickname: _____

Address: _____

City, State & Zip Code: _____

Cell Phone #: _____ Home phone (if applicable) _____

Birthdate: _____ Age: _____ Gender (circle): Male Female Other Prefer not to specify

Email: _____ Social Security # _____

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

Race: _____

EMERGENCY CONTACT:

Name	Phone	Relationship
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If under 18: Parent 1: Name _____ Cell _____

Parent 2: Name _____ Cell _____

RESPONSIBLE PARTY (If patient is a minor please put in the person who is accompanying the minor)

Name: _____ Relationship to patient: _____

Address: _____ Phone#: _____
(if different from patient)

Date of Birth: _____ Social Security # _____

DOCTOR INFORMATION:

Primary Care Doctor (name, not practice) _____

Primary Care Doctor Phone# _____ Fax # _____

Full Address: _____

Update/Change _____ New _____ Office Use: Patient # _____ Facility _____ Doctor _____

PRIMARY INSURANCE INFORMATION

Name of Policy Holder: _____ Relationship to patient: _____

Policy Holder Birthdate: _____ Social Security #: _____

Home address (if different from above): _____ Cell #: _____

Medical Insurance Company name: _____ Eff.date: _____

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

Type of policy: (circle) PPO HMO* POS* MEDICARE SELF PAY PUBLIC AID OTHER

*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's 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 from your primary care doctor.

SECONDARY INSURANCE INFORMATION (if applicable)

Name of Policy Holder: _____ Relationship to patient: _____

Policy Holder Birthdate: _____ Social Security #: _____

Home address (if different from above): _____ Cell #: _____

Medical Insurance Company name: _____ Eff.date: _____

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

Type of policy: (circle) PPO HMO* POS* MEDICARE SELF PAY **PUBLIC AID OTHER

** We do not accept medicaid as a secondary insurance unless the primary is medicare.

ON THE DAY OF SERVICE:

SELF PAY PATIENTS: ALL FEES ARE DUE AT THE TIME OF SERVICE

COPAYS: ALL COPAYS ARE DUE AT THE TIME OF SERVICE FOR PPO AND HMO PATIENTS

PLEASE NOTE: YOU ARE RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE

I authorize the 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 of the above named patient.

Signature Relationship to Patient Date