THE ALLERGY & ASTHMA CENTERS OF CAPE COD

PATIENT INFORMATION FORM

Please print and complete all sections.			**Today's Date:** _____
Patient's Name:		DOB:	☐ F ☐ M
Mailing Address:			
City:	State:	Zip Code:	
Home Phone:		Work Phone:	
Cell Phone:		Best # to reach you during the day: ☐ Cell ☐ Home ☐ Work	
Email Address:		Your email is protected by and only used by Allergy & Asthma Centers of Cape Cod	
Social Security #:		Marital Status: ☐ M ☐ S ☐ D ☐ W	
Occupation:	Employer:	Phone:	
Name of Person Responsible for Account:			
Primary Care Physician (PCP):		Phone:	
Preferred Pharmacy Name:		Preferred Pharmacy Phone:	
Emergency Contact Name:			
Phone:		Relationship:	
Race/Ethnicity: ☐ African American ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Caucasian ☐ Mexican American ☐ Other:_____ ☐ Decline to state Ethnicity:_____			

Pediatrics: If Patient is a child, or a dependent on parent's health insurance plan, please complete the following information.		
Parent Name: ☐ Father:	☐ Mother:	Phone:
Name of Employer & Work Address (if different from above):		
Parent's DOB: Mother:	Father:	

Insurance:			
Primary Insurance Company:			
Insured's Name:		Relationship to Patient: (If not self)	
ID#:	Group#:	Insured's SSN:	Insured's DOB:
Secondary Insurance Company:			
Insured's Name:		Relationship to Patient: (If not self)	
ID#:	Group#:	Insured's SSN:	Insured's DOB:
Please tell us how you heard about our practice?			
☐ Physician: Name_____ ☐ PCP ☐ Specialist ☐ Ins. Company ☐ Pharmacy			
☐ AACCC Patient: _____ ☐ AACCC Employee: _____			
☐ Our Website ☐ Web ☐ Yellow Pages ☐ Advertisement:_____ ☐ Other:_____			

I authorize payment of insurance benefits directly to The Allergy & Asthma Centers of Cape Cod or supplier for these services. I authorize the release of any medical information necessary to process all insurance claims. I understand that co-payments, deductibles, co-insurance & fees for services not covered by my insurance are my responsibility. I understand that I am responsible for obtaining, & keeping current, referrals from my Primary Care Physician if required by my insurance plan & that I am financially responsible for any additional charges that occur if the necessary referrals are not provided. If my insurance denies payment or I have no insurance, I understand that I am financially responsible for all charges. By signing this document I state that all information given is current and accurate.

Signature_____ **Relationship to Patient** _____ **Date**_____

Patient or person authorized to consent for patient (If signing for a minor)