Central Indiana Allergy ***Patient Registration***

PATIENT INFORMATION

First Name Middle Name/Initial Last Name

Address Street Apt # City State Zip

( ) Area Code & Telephone Number Emergency Contact Emergency Contact Phone Relationship

DOB: Month/Day/Year Male or Female Marital Status - - Social Security Number Cell Phone Number

Primary Care Physician Referral required from PCP? Yes / No Referring Physician, if different

Employer/School Name Address City State Zip Phone Ext

PARENT/GUARDIAN INFORMATION

Father: Mother: Legal Guardian:

Address Street Apt # City State Zip

( ) Area Code & Telephone Number Cell Phone Number - - Social Security Number

PRIMARY INSURANCE: *Must be completed in full along with a photo copy of the insurance card.

Insurance Name Address City State Zip Phone

Group # Policy# Relationship to Patient:

Subscriber Name: DOB: SS #:

SECONDARY INSURANCE: *Must be completed in full along with a photo copy of the insurance card.

Insurance Name Address City State Zip Phone

Group # Policy# Relationship to Patient:

Subscriber Name: DOB: SS #:

How did you come to select our practice? Check one: _____ Dr. Referred _____ Friend Referred _____Family Recommends
_____ Yellow Pages _____ Referral Service _____Newspaper

Signature of Patient or Guarantor **Date**

APPLIES TO MEDICARE PATIENTS ONLY: I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to provider for any services furnished me by their physicians. I authorize my holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. APPLIES TO MEDIGAP PATIENTS ONLY: I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to provider for any services furnished me by their physicians. I authorize any holder of medical information about me to release to my (Insurance Co. Name) _____ any information needed to determine these benefits payable for services.

ALL PATIENTS and/or GUARANTOR: I hereby authorize the release of any medical information necessary to process any and all of my claims, or facts concerning the treatment provided. I further authorize my insurance company to pay direct to Provider, the medical benefits otherwise payable to me. I understand that I am financially responsible for those charges not paid by my insurance. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain in effect until such time as revoked by me. In the case of default payment, I promise to pay any legal interest on the balance due together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.