ALLERGY AND ASTHMA INSTITUTE

PATIENT INFORMATION

Account #_________________

(PLEASE PRINT) Today's Date: ____________________

Patient's Name: ____________________________ Age: ________ Sex: ________ DOB: ____________
(LAST) (FIRST)

*If patient is a minor child please list: Mother's name ____________________________________
Father's name ____________________________________

Patient Social Security #______-_______-_______

Home Address: ____

City:_____________________ State ________ ZIP: ____________ Telephone: ( ) ______________
Cell phone: ( ) ______________
E-Mail ________________________

Do you have Medical Insurance? □ yes □ no If yes, please list all information below.

Name of Insured: ____

Name of Insurance Co.: _________________________ Do you have a deductible? Yes ___ No ___

Group # ________________________ Subscriber # ____

Insured Employed by: ____

Occupation: _____________________ Bus. Phone ( ) ______________ SS# ______-______-______

HOW DID YOU HEAR ABOUT OUR PRACTICE?
Referred by Doctor: ___________________________________ Telephone: ( ) ______________
Address: _________________________________ City: _______________ ZIP: ___________________

Referred by Friend: ____________________________________

Referred by Ins. Co______ Internet: _____ Phone book: ___________ Other: _________________

Who to contact in case of emergency: ____

Relationship: ______________________________________ Telephone: ( ) __________________

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN FOR MEDICAL SERVICES RENDERED. I AUTHORIZED THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE BENEFITS.

PLEASE BE AWARE THAT IF YOU HAVE A DEDUCTIBLE YOU WILL BE BILLED AFTER THE INSURANCE IS PROCESSED. PLEASE FEEL FREE TO DISCUSS ANY QUESTIONS REGARDING YOUR DEDUCTIBLE WITH OUR OFFICE MANAGER PRIOR TO YOUR VISIT.

I understand and agree to the above statements. Patient's Signature: _________________________________

24 hour notice is required to cancel all scheduled appointments.
This office reserves the right to charge a cancellation fee if this requirement not met.