West Texas Allergy

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Date Patient Called: _____

Appointment Date & Time:
_____

_____

Patient Information

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____
Last First Middle Initial

Soc. Sec. #:_____Birthdate: _____

Home Address:_____

○ Male ○ Female

Email Address: _____

Patient Employed by: _____ Occupation: _____

Referred by: _____

Person Responsible for Account: _____

Relationship to Patient_____ Birthdate:_____ Phone: _____

Address (if different from above):_____

Soc. Sec # of insured: _____ Employed by:_____

Insurance Company: _____ Insurance Address: _____

Group No. _____ Subscriber ID: _____

Is patient covered by additional insurance: ○ Yes ○ No

Secondary Insurance Subscriber Name: _____

Relationship to Patient: _____ Birthdate: _____

Soc. Sec. #_____

Address(if different from above):_____

Phone: _____ Employed by: _____

Insurance Company: _____ Insurance Address:_____

Group No. _____ Subscriber ID: _____

Patient Benefits

Patient Name: _____Date of Birth: _____

Insurance Company: _____

Group No: _____ Subscriber ID: _____

Copay: _____ Effective Date: _____

Benefits:

Office Visit: _____Skin Test (95004):_____

Intradermal (95024): _____ Spiro (94060): _____

Extract/Serum (95165):_____

Injections (95117): _____

Individual Deductible: _____ Amount Met at Time of verification: _____

Family Deductible: _____ Amount Met at Time of verification: _____

Individual Out of Pocket: _____ Amount Met at Time of verification: _____

Family Out of Pocket: _____ Amount Met at Time of verification: _____

Secondary Insurance Company: _____
Group No: _____ Subscriber ID: _____
Copay: _____ Effective Date: _____
Benefits:

Office Visit: _____
Serum: _____
Injections:_____
Skin Testing: _____
Individual Deductible: _____ Amount Met at Time of verification: _____
Family Deductible: _____ Amount Met at Time of verification: _____
Individual Out of Pocket: _____ Amount Met at Time of verification: _____
Family Out of Pocket: _____ Amount Met at Time of verification: _____

☐ Verified by Phone - Date: _____ Spoke with:_____ Reference #:_____

☐ Verified Online ☐ Entered into Centricity

☐ Insurance Card printed (if possible)

☐ Benefits printed out

Verified by: _____ Date: _____