Allergy & Asthma Physicians, S.C.

Name: _____ SS # _____

Address: _____

City: _____State: _____ Zip Code: _____

Preferred Phone:_____ **Home Mobile Work** Additional Phone: _____ **Home Mobile Work**

Birthdate: _____ Marital Status: _____ Student? no full time part time

Who is your Primary Care Doctor: _____

Address: _____ Phone: _____

Who referred you: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship:_____

Who is responsible for payment*? Address, if different:_____

*(If patient is a minor)

❖ **PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST**. ❖

Insurance Company: _____ Do you want us to bill your insurance? yes no

Group #: _____ Subscriber ID #: _____

Primary Subscriber: _____ Relationship to insured: **Self Spouse Child**

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I authorize the release of any medical information necessary to process my insurance claim to my insurance company. I authorize the payment of medical benefits to Allergy & Asthma Physicians, unless otherwise noted. I understand that Allergy & Asthma Physicians will bill my *primary* insurance as a courtesy to me. Any balance that remains unpaid after 45 days will be my responsibility.

Signature: ✕_____ Date: _____

I acknowledge receipt of Allergy & Asthma Physicians Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that Allergy & Asthma Physicians has reserved a right to change the privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signature: ✕_____ Date: _____

Relationship, if not patient: _____