

Account No: _____ Dr.# _____ FC _____ Diag. _____

PATIENT INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____

Mailing Address: _____ City _____ St. _____ Zip _____

Residence Address: _____ City _____ St. _____ Zip _____

Phone: _____ Age _____ Sex: M F Marital Status: S M W D Sep S.S.# _____

Patient's Employer & Address: _____

Occupation: _____ Phone: _____

Spouse or Parents Name and Address _____

Employed By: _____ Occupation: _____ Phone: _____

... Spouses Name and Address (It Divorced or Separated): _____

City _____ City _____ State _____ Zip _____ Phone: _____

Responsible Party: _____ D.O.B. _____ S.S.# _____

Address: _____ City _____ State _____ Zip _____ Phone: _____

Emergency contact outside of household: _____ Phone: _____

Address: _____ City _____ State _____ Zip _____

Has any member of your immediate family been treated at this clinic? _____

Name _____ How did you find out about us? _____

Family Physician Name and Address: _____

INSURANCE

PLEASE READ: The patient is responsible for all fees, regardless of insurance coverage. We appreciate payment at the time services are rendered. We give you an itemized copy of the services which you present to your insurance company for reimbursement.

Medicaid patients must present a current card at the time services are rendered.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Allergy Care Center to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.

Date: _____ Signature _____

Insurance Company: _____ Effective Date: _____

Insured: _____ D.O.B.: _____ Employer: _____

ID# _____ Group #- _____

Other insurance: _____ Effective Date: _____

Please present insurance card upon appointment.

NOTES

Please notify our office of any changes as soon as possible.