

**Patient Information**

Date: \_\_\_\_\_

Acct. No.: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

Mailing Address: \_\_\_\_\_

Social Security No.: \_\_\_/\_\_\_/\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Referred By: \_\_\_\_\_

Home Phone No.: \_\_\_/\_\_\_/\_\_\_ Fax: \_\_\_/\_\_\_/\_\_\_

Family Physician: \_\_\_\_\_

Cell Phone No.: \_\_\_/\_\_\_/\_\_\_ Work: \_\_\_/\_\_\_/\_\_\_

Employer: \_\_\_\_\_

Emergency Phone: \_\_\_/\_\_\_/\_\_\_ Ext.: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency Contact Name & Relationship: \_\_\_\_\_

Pharmacy Used for Prescriptions: \_\_\_\_\_

Marital Status: S M D W

Sex: M F Smoker: Y N Full-time Student: Y N

Place of Residence: House Apartment Nursing Home School Other \_\_\_\_\_

How did you hear about us? Patient Doctor Ins. Co. Paper Phone Book Web Search Other \_\_\_\_\_

**The person who is responsible for my bills and/or carries my insurance coverage**

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone No.: \_\_\_/\_\_\_/\_\_\_ Ext.: \_\_\_\_\_

Home Phone No.: \_\_\_/\_\_\_/\_\_\_

Occupation: \_\_\_\_\_

Social Security No.: \_\_\_/\_\_\_/\_\_\_

Birthdate: \_\_\_\_\_

Marital Status: S M D W

Sex: M F

**Insurance Information**

Name of Insurance Company: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy No.: \_\_\_\_\_ Group No.: \_\_\_\_\_

Effective Date of Primary Insurance: \_\_\_\_\_

Effective Date of Secondary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy No.: \_\_\_\_\_ Group No.: \_\_\_\_\_

Primary Care Physician (as stated on your insurance card): \_\_\_\_\_

I certify that the information given by me in applying for payment under my insurance carrier is correct. I authorize any holder of medical/insurance information about me to release to my physician/insurance any information required to process my claims. I understand that to knowingly withhold insurance reimbursement payments for medical services rendered would be committing a wrongful act. I request that reimbursement from my insurance(s) be made payable to the physician's office that has rendered services to me. I attest that the information I have given on these forms is true and correct to the best of my knowledge.

Signature

Date

Asthma & Allergy Associates P.C.

1-800-88ASTHMA