

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 Phone No.: ____/____/____ Family Physician: _____

Cell Phone No.: ____/____/____ Work Phone No.: ____/____/____ Employer: _____

Emergency Phone No.: ____/____/____ Ext.: _____ Occupation: _____

Emergency Contact Name and Relationship: _____

Pharmacy Used for Prescriptions: _____ Marital Status: S M D W

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

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

Email: _____

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