

PATIENT INFORMATION SHEET

Please Circle One: Mrs. Ms. Miss Mr. Child Single Married Divorced Widowed

Patient Name: _____

Date of Birth _____ Age _____ SSN _____ Male _____ Female _____

Home Address _____ City,St,Zip _____

Home Phone _____ Cell # _____

Race White Asian Black/ African American Native Hawaiian or Other Pacific Islander American Indian-Alaskan Native
 Other Race

Ethnicity Hispanic Latino Non-Hispanic or Latino Preferred Language: English Other: _____

EMAIL _____ Driver's Lic. # _____

Preferred Means of Communication(Please Check One): Email Home Phone Cell Phone Mail Any

How did you hear about us? (Please Circle One) Physician Name: _____ Community Event Name: _____
Flyer Browsing the web Friend Yelp Google Yahoo PPO Insurance Directory

FAMILY PHYSICIAN _____ **PHYSICIAN PHONE #** _____

IF PATIENT IS A MINOR:

Father's Name: _____ Mother's Name: _____

Birth day _____ Birth day _____

Occupation _____ Occupation _____

Employer _____ Employer _____

Street _____ Street _____

City,St,Zip Code _____ City,St,Zip code _____

Phone # _____ Phone # _____

EMERGENCY CONTACT _____ **RELATIONSHIP** _____ **PHONE #** _____

PRIMARY INSURANCE: _____ circle: EPO / HMO / PPO / POS

Primary Insured Name _____ D.O.B. _____ SS# _____

Insured's Employer _____ Occupation _____

Insurance Company Name _____ DL # _____

Insurance Address _____ Effective Date _____

Insurance Ph. # _____ Relationship to Subscriber _____

ID # on Card _____ Group # _____

SECONDARY INSURANCE: _____ circle: EPO / HMO / PPO / POS

Primary Insured Name _____ D.O.B. _____ SS# _____

Insured's Employer _____ Occupation _____

Insurance Company Name _____ DL # _____

Insurance Address _____ Effective Date _____

Insurance Ph. # _____ Effective Date _____

ID # on Card _____ Group # _____

*** PLEASE READ ***

INSURANCE INFORMATION: I acknowledge that the physicians of Allergy and Asthma Assoc. may or may not be a part of the provider network for my insurance company and that it is my responsibility to verify that the providers are participating in my network. Please give your card(s) to the receptionist so we may keep a copy on file. All professional services rendered are charged to the patient/guardian. The patient is responsible for all fees regardless of insurance coverage. I hereby authorize Allergy and Asthma Assoc. to furnish all information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and that it is my responsibility to ask for an estimation of the costs of any tests being recommended/ordered prior to them being performed. My signature below indicates that I have read and agree to these said statements.

Signature: _____ Relationship: _____ Date: _____

May we send appointment reminders and notifications of documents needing updating via email/text messaging?

Signature Authorizing Use of Email/Text Messages: _____ Date: _____