PATIENT INFORMATION — PLEASE PRINT

Name of Patient _____Date_____

Home Address_____ Home Telephone _____

City _____ State _____ Zipcode_____

Work Telephone _____Cellular Telephone_____E-Mail _____

Date of Birth _____ Sex: ○ M ○ F ○ Single ○ Married ○ Widow ○ Divorce

Social Security Number_____

If Married – Name of Spouse_____

If Minor – Name of Parents _____

Person Financially Responsible for Patient _____ Relationship_____

Do you have an advanced directive for health care? ○ Y ○ N Allergies _____

Emergency Contact _____ Relationship _____ Telephone _____

Whom May We Thank for Referring You_____ HIPAA Read / Signed _____

PRIMARY INSURANCE

Name of Insured _____Relationship to Patient_____

Address (if different from patient) _____

Insured's Date of Birth _____ Social Security Number _____

Insured's Employer _____ Work Telephone _____

Insurance Plan Name _____

Policy Number _____ Group Number_____

Co – Pay _____ Deductible _____ Type of Plan ○ Medicare ○ HMO ○ PPO ○ Commercial

Are you familiar with coverage limitations of your plan?_____

SECONDARY INSURANCE

Name of Insured _____Relationship to Patient_____

Address (if different from patient) _____

Insured's Date of Birth _____ Social Security Number _____

Insured's Employer _____ Work Telephone _____

Insurance Plan Name _____

Policy Number _____ Group Number_____

Co – Pay _____ Deductible _____ Type of Plan ○ Medicare ○ HMO ○ PPO ○ Commercial

Are you familiar with coverage limitations of your plan?_____

ASSIGMENT OF MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made to me or on my behalf to Asthma, Allergy & Immunology Institute, PLC for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I choose to revoke it.

Signed_____Date_____

ASSIGNMENT OF INSURANCE BENEFITS

I request that payment of authorized insurance benefits be made to me or on my behalf to Asthma, Allergy & Immunology Institute, PLC for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the _____ (name of insurance company) and its agents any information needed to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I choose to revoke it.

Signed _____ Date _____