

# ALLERGY AND ASTHMA ASSOCIATES, PC

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Board Certified Physicians in Allergy and Immunology

## Patient Registration Form - Please Print

Patient \_\_\_\_\_ Sex  M  F Date of Birth \_\_\_\_\_  
Last name First name Middle Initial  
Occupation \_\_\_\_\_ SS# \_\_\_\_\_  Single  Married  Widowed  Divorced  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone #'s: Home \_\_\_\_\_ Cell \_\_\_\_\_  
Work \_\_\_\_\_ Email: \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

Do you have medical insurance?  Yes  No

Does your insurance require a referral?  Yes  No

Name of Primary Insurance \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
ID or Policy No \_\_\_\_\_ Group No \_\_\_\_\_ Effective Date \_\_\_\_\_

Guarantor/Subscriber \_\_\_\_\_ self (Name if other than self) \_\_\_\_\_  
Address (if different than above) \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Date of Birth \_\_\_\_\_  
SSN \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Who is financially responsible for this account (if different than guarantor/subscriber)? \_\_\_\_\_  
Address (if different than above) \_\_\_\_\_

**For Medicare/Tricare Patients Only:** Name of Secondary Insurance \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
ID or Policy No \_\_\_\_\_ Group No \_\_\_\_\_ Effective Date \_\_\_\_\_

In case of emergency, who should be notified?

Name \_\_\_\_\_ Phone number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

I hereby authorize Allergy and Asthma Associates, P.C. to treat the above named patient and apply for benefits on my behalf for covered services rendered. I request payment by the insurance company listed above be made directly to Allergy and Asthma Associates, PC (or in the case of Medicare Part B benefits, to myself or the party who accepts assignment). I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information including medical information for this or any related claim, to the above-named billing agent (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I authorize the release of any medical or other information necessary to process my insurance claim(s). I understand that as a patient or the responsible party for a patient, I am ultimately responsible for payment of my bill. I also take full responsibility for obtaining a valid referral, if it is required by my insurance company. I take full financial responsibility for any visits or treatments not covered under a referral, and agree to be responsible for the cost of collection efforts including reasonable attorney's fees.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES: By signing below I am acknowledging that Allergy and Asthma Associates, PC have made available to me their *Notice of Privacy Practices* that provides a description of Health Care Information uses and disclosures.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Patient or Responsible Party

\_\_\_\_\_ Printed Name