Allergy Immunology Clinic Patient Information Form

Patient

Last Name ______ First Name ______ SS ______ M / F Gender ______ DOB (MM/DD/YY) ______

Street Address ______ City ______ State ______ Zip Code ______

☐ (____) ______ Home Telephone ☐ (____) ______ Work Telephone ☐ (____) ______ Cell Phone

Check box(es) if permission granted to leave medical information message.

Spouse/Parent Name ______ Spouse/Parent SSN# ______ S/P DOB (MM/DD/YY) ______ Spouse/Parent Employer ______

Other family members who are patients ______

Billing Information (if different from above)

Last Name ______ First Name ______ MI ______ SSN# ______ M / F Gender (circle) ______ DOB (MM/DD/YY) ______

Street Address ______ City ______ State ______ Zip Code ______

(____) ______ Home Telephone (____) ______ Work Telephone (____) ______ Cell Phone

Insurance

Primary Insurance Carrier ______ Membership # ______ Group # ______

Policy Holder (if different from above)

Policy Holder Full Name ______ Policy Holder SSN# ______ DOB (MM/DD/YY) ______ Relationship to Patient ______

Home Telephone ______ Work Telephone ______ Cell Phone ______ Employer ______

Secondary Insurance

Secondary Insurance ______ Membership # ______ Group # ______

Policy Holder (if different from above)

Policy Holder Full Name ______ Policy Holder SSN# ______ DOB (MM/DD/YY) ______ Relationship to Patient ______

Home Telephone ______ Work Telephone ______ Cell Phone ______ Employer ______

Emergency Information

Emergency Contact Full Name ______ Telephone # ______ Relationship to Patient ______

Primary Care Physician ______ Telephone # ______ Physician Address ______

Referring Physician (if different from above) ______ Telephone # ______ Physician Address ______

Assignment of Benefits I request that payment of authorized benefits be made to the Allergy Immunology Clinic for services received. I authorize medical information to be released to the insurance carrier(s) or to the Health Care Financing Administration and its agents for the purpose of processing the claim and/or determining benefits. This assignment will remain in effect until revoked by me in writing. A payment plan is available and can be arranged through the bookkeeper. Payment of this account is due thirty (30) days after receiving the statement. Your insurance carrier will be billed as a courtesy. However, you are ultimately responsible for payment of the account. A $45 fee will be charged for any checks returned to us by the bank. A $50 fee will be charged for appointments not kept and not cancelled within 24 hours notice.

To the best of my knowledge the information provided herein is accurate and I understand I am responsible for the payment of this account.

Signature ______ Date ______

---------------- **OFFICE USE ONLY** ----------------

Verified with patient ______ Updated records ______