Allergy Immunology Clinic Patient Information Form Registration Form – 05/21

Patient Information

Last Name _____ First Name _____ SS# _____ Gender _____ DOB (MM/DD/YY) _____

Street Address _____ City _____ State _____ Zip Code _____

☐ (____) _____ Home Telephone ☐ (____) _____ Work Telephone ☐ (____) _____ Cell Phone Marital status: S M D W

Check box(es) if permission granted to leave medical information message. ☐ OK to TEXT message Appointment reminder

Billing Information (if different from above)

Last Name _____ First Name _____ SS# _____ Gender _____ DOB (MM/DD/YY) _____

Street Address _____ City _____ State _____ Zip Code _____

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

Email Address _____

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

Other immediate family members who are patients _____

Emergency contact: _____ Name _____ Telephone

Insurance

Primary Insurance Carrier _____ Membership # _____ Group # _____

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

Employer _____ Telephone _____

Secondary Insurance

Secondary Insurance _____ Membership # _____ Group # _____

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

Employer _____ Telephone _____

Medical Information

Primary Care Physician _____ Primary Care Physician Address _____ Primary Care Physician Telephone _____

Referring Physician (if different from above) _____ Referring Physician Address _____ Telephone _____

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. We will bill your insurance carrier as a courtesy. However, you are ultimately responsible for payment of the account. **A $20 fee will be charged for any checks returned to us by the bank. A $25 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 computer _____