

**PLEASE PRINT**

Allergy Associates  
PATIENT INFORMATION FORM

Date: \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Name (Last, First, Middle Initial)		SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	G.P., Internist, Pediatrician	Telephone
Patient Address		Referring Doctor		Telephone
City	State	Zip	Employer's Name	Telephone
Telephone (    )	Cell # (    )	Date of Birth /    /	Employer's Address	City/State/Zip
Age	Social Security number	Driver's License number	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed How did you hear about us?

Patient's Secondary/Alternative Address	City/State/Zip
Comments:	

**RESPONSIBLE PARTY INFORMATION**    Responsible Party is  Patient  Parent/Guardian    Date of Birth \_\_\_\_\_  
Mo.    Day    Year

Responsible Party Name	Social Security Number	Driver's License Number
Address	City/State/Zip	
Telephone # (    )	Relationship to Patient	Employer Name/Phone Number
Employer Address		City/State/Zip

Spouse Name \_\_\_\_\_    Employer \_\_\_\_\_    Spouse Work # \_\_\_\_\_

EMERGENCY CONTACT PERSON \_\_\_\_\_ PHONE # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

<b>Primary Insurance    CARD MUST BE PRESENT</b>	<b>Medicare Secondary Information Only</b>
Insurance Name _____	Insurance Name _____
ID/Member # _____	ID/Member # _____
Group# _____ Employer _____	Group# _____
Subscriber Name _____	Subscriber Name _____
DOB _____	DOB _____

I certify that the information about is true to the best of my knowledge. I authorize Allergy Associates to submit a claim to Medicare/Insurance company for me and authorize insurance benefits be paid directly to the physician. I understand that I will obtain authorization, if necessary, prior to services; otherwise, I accept financial responsibility. I understand that I am responsible for deductibles, co-pays and/or co-insurance amounts at the time of service. In order to control the cost of billing, all payments are due at the time of each service. A service fee of \$5.00 will be added to each account for re-billing. I agree to reimburse you the fees of any collection agency, which may be based on a percentage at the maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, incurred in such collection efforts.

Date \_\_\_\_\_ Signature \_\_\_\_\_