PLEASE PRINT

Allergy Associates
PATIENT INFORMATION FORM Date: _____

PATIENT INFORMATION

Patient's Name (Last, First, Middle Initial) SEX ☐ Female ☐ 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 ☐ Separated How did you hear about us? ☐ Single ☐ Divorced ☐ Married ☐ Widowed

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	Employer Name/Phone Number
Telephone # Relationship to Patient ( )	Employer Address City/State/Zip

Spouse Name_____ Employer _____ Spouse Work # _____

EMERGENCY CONTACT PERSON _____PHONE #_____

Relationship to Patient_____

Primary Insurance CARD MUST BE PRESENT	Medicare Secondary Information Only
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_____