

**Patient**

\_\_\_\_\_ M / F \_\_\_\_\_ S / M / D / W  
 Last Name First Name MI SSN# Gender DOB (MM/DD/YY) Marital Status (circle)

\_\_\_\_\_  
 Street Address City State Zip Code

\_\_\_\_\_  
 Home Telephone Work Telephone Cell Phone Employer

\_\_\_\_\_  
 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)**

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

\_\_\_\_\_  
 Street Address City State Zip Code

\_\_\_\_\_  
 Home Telephone Work Telephone Cell Phone

**Insurance**

\_\_\_\_\_ Membership # \_\_\_\_\_ Group # \_\_\_\_\_  
 Primary Insurance Carrier

*Policy Holder (if different from above)*

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

\_\_\_\_\_  
 Home Telephone Work Telephone Cell Phone Employer

\_\_\_\_\_ Membership # \_\_\_\_\_ Group # \_\_\_\_\_  
 Secondary Insurance Carrier

*Policy Holder (if different from above)*

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

\_\_\_\_\_  
 Home Telephone Work Telephone Cell Phone Employer

**Emergency Information**

\_\_\_\_\_ Telephone # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Emergency Contact Full Name

\_\_\_\_\_ Telephone # \_\_\_\_\_ Physician Address \_\_\_\_\_  
 Primary Care Physician

\_\_\_\_\_ Telephone # \_\_\_\_\_ Physician Address \_\_\_\_\_  
 Referring Physician (if different from above)

**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 \_\_\_\_\_