



Patient # _____

PATIENT INFORMATION RECORD

NAME: _____
FIRST MIDDLE LAST

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SSN: _____ Marital Status: S () M () W () D () Sex: M () F () Date of Birth: _____

E-Mail Address: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Primary Care Physician: _____ Practice Name: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

How did you find us? Referred By: Physician _____ Yellow Pages Friend Ad Internet
Name

Spouses Name: _____ Occupation: _____

Spouses Employer: _____ Business Phone: _____

Employers Address: _____ City: _____ State: _____ Zip Code: _____

In Case of Emergency, Notify: _____ Phone Number: _____

IF PATIENT IS A MINOR OR STUDENT

Mother's Name: _____ Home Phone: _____ Cell Phone: _____

Mother's Employer: _____ Address: _____ City: _____ State: _____ Zip Code: _____

Business Phone: _____ Date of Birth: _____ SSN: _____ Driver License #: _____

Father's Name: _____ Home Phone: _____ Cell Phone: _____

Father's Employer: _____ Address: _____ City: _____ State: _____ Zip Code: _____

Business Phone: _____ Date of Birth: _____ SSN: _____ Driver License #: _____

INSURANCE COVERAGE INFORMATION

Primary Insurance Coverage:

Insured (Name on Card): _____ Insured ID # _____
Insurance Company Name: _____ Group # _____ Policy #: _____
Address: _____ Effective Date: _____

Secondary Insurance Coverage:

Insured (Name on Card): _____ Insured ID # _____
Insurance Company Name: _____ Group # _____ Policy #: _____
Address: _____ Effective Date: _____

Third Insurance Coverage:

Insured (Name on Card): _____ Insured ID # _____
Insurance Company Name: _____ Group # _____ Policy #: _____
Address: _____ Effective Date: _____

ASSIGNMENT OF BENEFITS TO THE PHYSICIAN

I hereby authorize Allergy & Asthma Care of Blakeney to release any medical information required during the course of examination and treatment and permit payment directly from my insurance company to them of any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage, including but not limited to coinsurance, copayments, deductibles and non-covered services. I also authorize the release of information to Health Care Financing Administration or its intermediaries or carriers needed for any Medicare claim to be filed. I further agree that a photocopy of this agreement shall be valid as the original.

Signature of Patient and/or Guardian if patient is a minor

Date

RELEASE OF MEDICAL INFORMATION

I hereby authorize Allergy & Asthma Care of Blakeney to release any medical information regarding the services performed to my personal (primary care) physician and/or insurance company.

Signature of Patient and/or Guardian if patient is a minor

Date

CONSENT TO TREAT

I understand that the diagnostic procedure(s) prescribed by my physician will be performed by Allergy & Asthma Care of Blakeney and I do hereby authorize and consent to such treatment procedures. I understand that if the patient is a minor (under age 18) he or she must be accompanied by a legal guardian at the time of treatment or must present a written letter signed by a legal guardian authorizing Allergy & Asthma Care of Blakeney to provide treatment to the patient. I further certify that no guarantee of assurance has been made as to the results which may be obtained.

Signature of Patient and/or Guardian if patient is a minor

Date