

ALLERGY ASTHMA SPECIALISTS, P.A.

Patient Name: _____ Home Phone:() _____ Cell Phone:() _____

Patient Address _____
STREET APARTMENT# CITY STATE ZIP

Sex: M or F DOB: ____/____/____ SS# _____

Marital Status: ?S ?M ?D ?W Smoker? Yes or No. Referred by _____
Last First

FOR PATIENTS 18 YEARS OLD AND OVER: Patient's Occupation: _____

Patient's Employer: _____ Work Phone () _____

Employer's Address: _____ Title _____

Spouse's Name: _____ Work Phone () _____

Spouse's Employer _____ Title _____

FOR PATIENTS UNDER 18 YEARS OLD:

GUARANTOR'S NAME: _____ Guarantor's SS# _____
Last First MI

Guarantor's Address: _____
STREET CITY STATE ZIP Parents' Names _____

Parent's Employer(s): _____ Title _____

Employer's Address(es) _____ Phone _____

FOR ALL PATIENTS:

Family Physician Name: _____ Address _____
Last First

How did you hear about us? ?Another Patient.? Physician. ?Yellow Pages. ?Managed care directory. ?Other(specify).

PPO/POS/HMO PATIENTS:

Please obtain prior authorization from your primary care physician before each visit to our office.

I understand if this is not done, I will be responsible for any unpaid balance. _____.(initial)

RELEASE OF INFORMATION:

I authorize Allergy Asthma Specialists, P.A. to release any information required to process my claim. I hereby certify the information provided is correct and true to the best of my knowledge.

Signature _____

ASSIGNMENT OF BENEFITS:

I hereby authorize payment directly to Allergy Asthma Specialists, P.A. of benefits and/or major medical benefits otherwise payable to me under the terms of my policy but not to exceed my indebtedness to said physician for his/her services. In making this assignment to the physician, I understand and agree that any unpaid balances not covered by this policy will be payable by me.

Signature _____ Date _____

In Case of Emergency (nearest relative): _____ Phone _____