ASTHMA & ALLERGY CENTER

PATIENT REGISTRATION

PATIENT'S NAME_____

FIRST MIDDLE LAST

HOME ADDRESS_____CITY/STATE/ZIP_____

MAILING ADDRESS_____CITY/STATE/ZIP_____

BIRTHDATE_____MALE_____FEMALE_____MARRIED_____SINGLE_____

HOME PHONE_____WORK PHONE_____

SOCIAL SECURITY NO._____REFERRING DOCTOR_____

ALLERGIES NO____ YES____ (PLEASE LIST)

_____

_____

EMPLOYER_____OCCUPATION_____

WORK PHONE _____ DATE EMPLOYED_____

ADDRESS_____CITY/STATE/ZIP_____

SPOUSE'S NAME_____

PERSON TO CONTACT IN AN EMERGENCY_____

RELATIONSHIP TO PATIENT_____PHONE_____

PERSON RESPONSIBLE FOR BILL :_____

NAME _____RELATIONSHIP TO PATIENT_____

_____

MEDICAL INSURANCE INFORMATION

_____

PRIMARY___ SECONDARY___ (COPY OF CARD REQUIRED)

_____ _____

NAME ON INSURANCE CARD POLICY NUMBER

I request that payment of authorized insurance benefits be made to ASTHMA & ALLERGY CENTER for any services furnished to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE SIGNED