DOCTOR _____ **UPDATE PATIENT INFORMATION** CHART# _____

or

Welcome To Our Office **NEW PATIENT INFORMATION** DATE _____

PATIENT'S NAME (Please Print)	MARITAL STATUS S M W D Sep	DATE OF BIRTH	AGE	SEX M F	SOCIAL SECURITY NO.

STREET ADDRESS or P.O. BOX	CITY AND STATE	ZIP CODE	HOME PHONE NO.

PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (Indicate if Student)	HOW LONG EMPLOYED	BUS. PHONE NO. EXT. NO.

EMPLOYER'S MAILING ADDRESS	CITY AND STATE	ZIP CODE

DRUG ALLERGIES, IF ANY

SPOUSE OR PARENT'S NAME	SOCIAL SECURITY NO.	DATE OF BIRTH

PERSON RESPONSIBLE FOR PAYMENT	STREET ADDRESS, CITY, STATE	ZIP CODE	HOME PHONE NO.

INSURANCE (Primary)	GIVE NAME OF POLICY HOLDER	DATE OF BIRTH	SOCIAL SECURITY NO.

INSURANCE (Secondary)	GIVE NAME OF POLICY HOLDER	DATE OF BIRTH	SOCIAL SECURITY NO.

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S)? INCLUDE NAME OF FAMILY MEMBER AND PHYSICIAN

REFERRED BY:

PLEASE READ: All Professional Services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/ Other Insurance company benefits be made either to me or on my behalf to ALLERGY, ASTHMA & SINUS CENTER, P.C. for any services furnished me by that party who accepts assignments physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare Other Insurance company claim.

I understand my signature requests the payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare Other Insurance company assigned cases the physician or supplier agrees to accept the charge determination of the Medicare Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are base upon the charge determination of the Medicare Other Insurance company.

Signature _____ **Date** _____