

CHART# _____

PATIENT INFORMATION

DOCTOR _____

(Please complete every line)

Welcome To Our Office

DATE _____

PATIENT'S NAME (Please Print)		MARITAL STATUS		DATE OF BIRTH	AGE	SEX	RACE	SOCIAL SECURITY NO.
		S	M	W	D	Sep		
						M	F	
STREET ADDRESS or P.O. BOX			CITY AND STATE		ZIP CODE		HOME PHONE NO.	
							CELL PHONE NO.	
PATIENT'S OR PARENT'S EMPLOYER			OCCUPATION (Indicate if Student)				WORK NO.	
EMAIL					DRIVER'S LICENSE			
EMPLOYER'S MAILING ADDRESS			CITY AND STATE			ZIP CODE		

DRUG ALLERGIES, IF ANY _____

SPOUSE OR PARENT'S NAME (Required for minors)	SOCIAL SECURITY NO.	DATE OF BIRTH

INSURANCE (Primary)	POLICY #	GIVE NAME OF POLICY HOLDER	DATE OF BIRTH	SOCIAL SECURITY NO.
INSURANCE (Secondary)	POLICY #	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 OR FAMILY PHYSICIAN:	PREFERRED PHARMACY:

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 _____