

ALLERGY & ASTHMA ASSOCIATES

Patient's Name		M _____ F _____	Date of Birth
Address (street)		(city)	(state) (zip code)
Home Telephone	Work Telephone		Cell Phone
Email Address		Social Security Number	
Marital Status			
Employer of Patient		Occupation	
Referred By		Primary Care Physician	
Person Responsible for Account			
Name		Relationship	
Address (street)		(city)	(state) (zip code)
Home Telephone	Work Telephone		Cell Phone
Email Address		Social Security Number	
Employer		Occupation	
Office Policy Regarding Payment			
<p>Co-payments and deductibles are due at the time services are rendered. We will happily submit all insurance claims as a courtesy to our patients.</p> <p>For those insurance plans requiring referrals, it is YOUR RESPONSIBILITY TO OBTAIN THE REFERRAL or payment will be expected when services are rendered.</p>			
Primary Insurance		Subscriber	
Policy/Membership Number		Group Number	
Claim Address			Telephone Number
Secondary Insurance		Subscriber	
Policy/Membership Number		Group Number	
Claim Address			Telephone Number
<p>I authorize the release of any medical or other information necessary to process an insurance claim. I authorize payment of medical benefits to the undersigned physician for services rendered. A photocopy of the agreement shall be valid as the original.</p> <p style="text-align: center;">Signature _____ Date _____</p> <p>I recognize that I am responsible for charges incurred for services rendered and agree to pay those charges. (deductibles, co-payments and non-covered services)</p> <p style="text-align: center;">Signature _____ Date _____</p>			