PATIENT INFORMATION

FIRST NAME:____________________ M.I.:________ LAST NAME:_________________________

BIRTH DATE:______________________ SEX: ☐ Male ☐ Female ☐ Other:_____

BILLING ADDRESS:____

APARTMENT NUMBER:__________ CITY:__________________ STATE:___ ZIP CODE:______

PRIMARY PHONE NUMBER:(___)_________________________________ CELL HOME WORK

PRIMARY EMAIL ADDRESS:____

REFERRING PHYSICIAN:____

PRIMARY PHYSICIAN:____

PHARMACY NAME:_________________________ PHARMACY PHONE NUMBER:____________

PHARMACY ADDRESS:____

EMERGENCY CONTACT NAME:________________________ RELATIONSHIP:_______________

EMERGENCY CONTACT PHONE NUMBER:____

PRIMARY INSURANCE & SECONDARY INSURANCE: *(provide card to receptionist)*

NAME OF SUBSCRIBER IF OTHER THAN SELF:____

RELATIONSHIP TO SUBSCRIBER IF OTHER THAN SELF:_________________________________

AUTHORIZATION AND ATTESTATION

I hereby assign to **Allergy MD** any insurance or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned by contractural arrangement, payment to the practice will be made by any insurance. I acknowledge that I am responsible for any co-payments and deductibles. These amounts are due at the time services are rendered. I understand that in the event that services rendered are not covered by my insurance, I will accept financial responsibility for all services provided to me.

I authorize the release of any medical information or other information as is necessary to process this claim. This is in compliance with the HIPPA Notice of Privacy Practice, which I attest to reading. This information is on file as a permanent record and may be amended if necessary.

X____ DATE:_____________________________