



**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: \_\_\_\_\_

DATE OF BIRTH OF 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 contractual 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: \_\_\_\_\_

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