Patient Registration

Patient Information	
Patient Name	Date of Birth
Address	SSN
City, State, Zip	Employer
Home Phone	Work Phone
Cell Phone	Name of Spouse (or parent if under 18)
Sex (M or F)	Spouse (or Parent's Employer)
Marital Status (M, S, D)	Spouse's (or Parent's) cell/work phone
Email Address	May we contact you via Email?
Name of Responsible Party	
Emergency Contact Name	Phone

Insurance Information (Primary)

_____

Cardholder's Name | Date of Birth | Address

_____

Insurance Company | Group Number | Phone Number

_____

Cardholder Relationship to Patient | Effective Coverage Date

Insurance Information (Secondary-if applicable)

_____

Cardholder's Name | Date of Birth | Address

_____

Insurance Company | Group Number | Phone Number

_____

Cardholder Relationship to Patient | Effective Coverage Date

Which pharmacy do you use? _____ Which location? _____

Whom may we thank for referring you today?_____

If you were not referred, how did you hear about us: _____

Please, read carefully <u>before</u> signing:

We will see that you get the best medical care and will make every reasonable effort to aid you in obtaining the maximum benefits allowed with your insurance coverage.

I also understand that this practice uses and discloses health information about me for treatment and to obtain payment for treatment. I hereby authorize payment of medical benefits from my insurance company to be paid to Allergy & Immunology Medical Center. In the case of non-payment, I understand that I am ultimately responsible for all the charges accrued while under the care of Allergy & Immunology Medical Center. I understand payment in accordance to my insurance contract is due at the time of service, unless prior arrangements are made in advance.

_____ _____ _____

Patient Signature | Printed Name | Date

ALLERGY & IMMUNOLOGY
MEDICAL CENTER