Asthma & Allergy Associates P.C.

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1-800-88ASTHMA

Patient Information

Patients Name: _____ Date of Birth: _____/_____/_____

Mailing Address: _____ Social Security No.: _____/_____/_____

City: _____State: _____Zip: _____ Referred By: _____

Home Phone No.: ____/____/___ Fax Phone No.: ____/____/____ Family Physician: _____

Cell Phone No.: ____/____/_____Work Phone No.: ____/___/____Employer: _____

Emergency Phone No.: ____/____/____ Ext.: _____ Occupation: _____

Emergency Contact Name and Relationship: _____

Gender Identity: Male Female Transgender Male Transgender Female Other:_____

Marital Status: S M D W Smoker: Y N Full-time Student: Y N Email:_____

How did you hear about us? Patient Referring Doctor/Nurse Practitioner/Physician Assistant Radio

Bus Ad Internet Other_____

The person who is responsible for my bills and/or carries my insurance coverage

Name: _____ Relationship to Patient: _____

Mailing Address: _____ Employer: _____

City: _____State: _____Zip: _____ Work Phone No.: ____/_____/_____Ext.: _____

Home Phone No.: _____/_____/_____ Occupation: _____

Social Security No.: _____/_____/_____ Birthdate: _____

Marital Status: S M D W Email:_____

Insurance Information

Name of Insurance Company: _____ Policyholder's Name: _____

Relationship to Patient: _____ Policy No.: _____Group No.: _____

Effective Date of Primary Insurance: _____ Effective Date of Secondary Insurance: _____

Secondary Insurance: _____ Policyholder's Name: _____

Relationship to Patient: _____ Policy No.: _____Group No.: _____

Primary Care Physician (as stated on your insurance card): _____

I certify that the information given by me in applying for payment under my insurance carrier is correct. I authorize any holder of medical/insurance information about me to release to my physician/insurance any information required to process my claims. I understand that to knowingly withhold insurance reimbursement payments for medical services rendered would be committing a wrongful act. I request that reimbursement from my insurance(s) be made payable to the physician's office that has rendered services to me. I attest that the information I have given on these forms is true and correct to the best of my knowledge.

_____ _____

Signature Date