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	

How did you first hear about us?	_____ Friend	_____ Physician	_____ Website	_____ Yellow Pages	_____ Other	Explain: __________

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

Co-payments and deductibles are due at the time services are rendered. We will happily submitt all insurance claims as a courtesy to our patients.

For those insurance plans requiring referrals, it is YOUR RESPONSIBILITY TO OBTAIN THE REFERRAL or payment will be expected when services are rendered.

Primary Insurance	Subscriber
Policy/Membership Number	Group Number
Claim Address	Telephone Number
Secondary Insurance	Subscriber
Policy/Membership Number	Group Number
Claim Address	Telephone Number

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.

Signature ______________________________ Date __________

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)

Signature ______________________________ Date __________