Account _________

NEW PATIENT INFORMATION

Dr. ________________________

Appt date________ Time______

Patient's Name	Sex	Marital Status Single Married Divorced Widowed Other

Address	City	State	Zip	Home Phone Number

Birth Date	Driver's License Number	Social Security Number	E Mail Address

Patient's Employer Name/Address	Office Phone Number

Family Physician/Address	Referred by

Person Responsible for Payment	Social Security Number	Relationship to Patient Self Spouse Parent Employer Other

Address	Driver's License	Birth Date	Home Phone Number

Employer's Name/Address

Occupation	Office Phone Number

Has any member of your family been a patient at Allergy Clinic? ☐ **Yes** ☐ **No**
Names

Preferred Language: ____

Race ☐ **White** ☐ **Black or African American** ☐ **Asian**
☐ **Hispanic or Latino** ☐ **Amercian Indian or Alaskan Native**
☐ **Native Hawaiian or Other Pacific Islander**
☐ **I decline to identify race**

Ethnicity ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino**
☐ **I decline to identify ethnicity**

Other than Responsible Party, In Case of Emergency Contact:	Relationship to Patient Self Spouse Parent Employer Other

Address	Phone Number

Name of Primary Insurance Company	# to verify insurance	Name of Policy Holder

Policy or Certificate Number	Group Number	Patient's Relationship to Policy Holder Self Spouse Child Employer Other

Name of Secondary Insurance Company	# to verify insurance	Name of Policy Holder

Policy or Certificate Number	Group Number	Patient's Relationship to Policy Holder Self Spouse Child Employer Other

Is you present condition the result of on-the-job injury? ☐ **Yes** ☐ **No**

Benefits: OV $__________; I $_________; V $_________; Tst $_________; Lab/X-ray $_________; Ded $_______; How much is met $__________________

Ref Req: OV_____ ;V _____; I_____; Auth # ______________________; Exp:___________________ PER:___ ____

Effective date: ______________________________ **Address to mail claims:**____ ____________

To the best of my knowledge the above information is accurate and true.

The Patient is responsible for the payment of all professional services rendered regardless of insurance coverage. It is customary to pay for services when received unless other arrangements have been made **in advance**. I understand that I am financially responsible to Allergy Clinic for charges not covered by my insurance and will be billed accordingly. If applicable, I also understand that if I do not follow the requirement as outlined in my managed care benefit plan (referral form, authorizations, etc.), I will be financially responsible for these charges. Upon default I am subject to all reasonable costs of collection and/or attorney fees.

I hereby authorize the release of information to insurance carriers concerning my illness and treatment, and I hereby assign to the physician all payments for medical services rendered to me or to my dependents.

____ _______________________________________

Signature Date