ADVANCED ALLERGY, ASTHMA & SINUSITIS P.C.

PATIENT INFORMATION

Patient Name: _____ Soc. Sec. #: _____

Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____ Age: ____

Sex: M F Marital Status: S M D W

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ E-Mail Address _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: (____) _____

EMPLOYER

Name: _____

Address: _____

PRIMARY CARE PHYSICIAN or REFERRING PHYSICIAN (to whom reports may be sent)

Name: _____ Phone: (____) _____

Address: _____

WHO REFERRED YOU TO THIS OFFICE?

Referring Physician Name: _____ Friend Name: _____

□ HMO or Health Insurance Company □ Yellow Pages □ Website □ Other _____

INSURANCE INFORMATION

	#1	**#2**
Insurance Company		
Address		
City, State, Zip		
Phone #		
Policyholder Name		
Insured's Birthdate, SS#		
Relationship to Patient		
Policy #, Group #		
Co-Pay Amount		

I have received a copy of the Advanced Allergy, Asthma and Sinusitis P.C.'s Notice of Privacy Practices (HIPAA). I authorize the release of medical information necessary to communicate with referring physicians and to process insurance claims. In accordance with medical treatment, there may be procedures or tests performed at additional cost. I authorize direct payment of covered benefits to the provider of professional services. The patient is responsible for all fees, regardless of insurance coverage. Payment for office visits is expected at the time of service. Credit cards or Debit Cards may be used, in addition to cash or check.

Date: _____ Patient Signature: _____