



Allergy/Immunology Associates Inc.

PATIENT INFORMATION

Title: _____ First Name: _____ MI: _____ Last Name _____

Gender: _____ Marital Status: _____ Date of Birth _____ SS#: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Employer Name: _____

Would you like TEXT appointment reminders / confirmations? YES NO E-mail: _____

How did you hear about our office? _____

Referring Provider: _____ Specialty: _____ Phone: _____ Fax: _____

GUARANTOR INFORMATION (person assuming financial responsibility for this account)

Title: _____ First Name: _____ MI: _____ Last Name _____

Gender: _____ Marital Status: _____ Date of Birth _____ SS#: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Employer Name: _____

Employer Phone Number: _____ Relationship to Patient: _____

PREFERRED PHARMACY INFORMATION:

Pharmacy Name: _____

Phone Number: _____ Fax Number: _____

Address: _____ City: _____ State: _____ Zip: _____

PLEASE BE SURE TO ANSWER ALL QUESTIONS ON THIS FORM BEFORE COMPLETING THE OTHER SIDE



Allergy/Immunology Associates Inc.

INSURANCE COMPANY INFORMATION

If no insurance information is given your account will be placed in a SELF PAY status and you will be expected to pay for your visit at the time of service

Primary Company Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Effective date of insurance: _____ Copay Amount (specialist) _____

Secondary Company Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Effective date of insurance: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____

I authorize the above provider to release my medical/financial information to my insurance, third party payer, or this provider's collection agent, attorneys, and consultants necessary to pay for the services rendered. I also know that I am responsible for deductibles, co-insurances, and any services not covered by my insurance company. If the patient is a minor, I as the parent/guardian authorize treatment. If self pay, I will be responsible for ALL charges. I further authorize all payments to be made directly to Allergy/Immunology Associates, Inc. (this provider)

Signature of patient/responsible party: _____ Date: _____

I hereby acknowledge that I have received and read the privacy policy of Allergy/Immunology Associates, Inc., and have been given the opportunity to ask questions regarding this policy.

Signature of patient/responsible party: _____ Date: _____