

Allergy, Asthma and Sinus Center, PC

Patient's Name _____ Age _____
(First) (MI) (Last)

Address _____

City, State, Zip _____

Home # (____) _____ Cell # (____) _____ Date of Birth ____/____/____ Sex M F
o Married o Single o Divorced
SSN _____ Work# (____) _____ o Separated o Widowed o Other

o Employed o Student Employer/Occupation _____

E-mail address _____

<p>Primary Insurance _____ Phone # (____) _____</p> <p>Insurance Address _____</p> <p>ID # _____ Group # _____</p> <p>Name of Insured _____ Employer _____ Relationship _____</p> <p>Insured's Social Security _____ Date of Birth _____</p> <p>Referral Required Y N Copay \$ _____</p> <p>_____</p> <p>Secondary Insurance _____ Phone # (____) _____</p> <p>Insurance Address _____</p> <p>ID # _____ Group # _____</p> <p>Name of Insured _____ Employer _____ Relationship _____</p> <p>Insured's Social Security _____ Date of Birth _____</p> <p>_____</p>

Primary Care Physician _____ Phone # (____) _____

Referring Physician _____ Phone # (____) _____

Pharmacy _____ **Location** _____ Phone # (____) _____

I hereby authorize Allergy, Asthma and Sinus Center to release the information requested to the insurance company named hereon. I hereby assign payment directly to the above named Physician of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I agree that in the event that my account must be turned over to an attorney/collection agency, that I will be responsible for collection fees, attorney fees, court costs, and interest.

Signature _____ **Date** _____

Patient/Guardian Signature