ADULT & PEDIATRIC ALLERGY ASSOCIATES, P.C.

Patient Registration Form

ACCT#

PATIENT INFORMATION

Last Name _____ Gender M / F Marital Status _____
First Name _____ M. Init. _____ Birth Date _____ Age _____
Address _____ Home Phone _____
City/ST/Zip _____ Cell Phone_____Text: Y/N
SS# _____-_____-_____ Work Phone _____

Preferred Language:_____ Race:_____
Communication Preference: Phone: cell or work or home? Ethnic Background:_____
OK to leave message Yes____ No____ E-Mail Address_____

RESPONSIBLE PARTY

Last Name _____ Gender M / F Marital Status _____
First Name _____ M. Init. _____ Birth Date_____
Address _____ Cell/Home #_____
City/ST/Zip _____ Soc Sec # _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____
Telephone _____

REFERAL INFORMATION

Primary Care Physician _____ How did you hear about our office? _____
Name of Dr. Referring _____

INSURANCE INFORMATION

Primary Insurance _____
Insured ID # _____
Group # _____
Mailing Address _____
City/ST/Zip _____
Telephone # _____
Policy Owner _____
SS# _____
Birthdate _____
Policy Holder Address _____

Patient Relation to PT _____

Secondary Insurance _____
Insured ID # _____
Group # _____
Mailing Address _____
City/ST/Zip _____
Telephone # _____
Policy Owner _____
SS# _____
Birthdate _____
Policy Holder Address _____

Patient Relation to PT _____

FINANCIAL POLICY, ASSIGNMENT AND RELEASE OF MEDICAL BENEFITS

Our patients are required to pay all deductibles, co-payments and co-insurance amounts at the time of service. Any balance over 30 days will be subject to 18% interest and attorney's collection fees. I hereby authorize direct payment of my insurance benefits to Adult and Pediatric Allergy Associates, P.C. I understand that I am financially responsible for this bill regardless of any insurance coverage. I also authorize the physician to release any information necessary to process this claim. I further agree to pay all collection costs that may be incurred to enforce collection of any amounts outstanding. I understand there is a $50 charge for no show visits or cancellations not made within 24 hours of the visit.

Date _____ Patient Signature or Legal Guardian _____