Allergy & Immunology, PLC's

ASTHMA & ALLERGY CENTER

Specializing in Allergic, Asthmatic & Sinus Conditions

Telephone (540) 343.7331 Fax (540) 343-7349

Acct. #____________

PATIENT INFORMATION SHEET

Patient's Name (Please Print and include middle initial)	SS#	Marital Status S M W D Sep	Sex M F	Age	Birth Date
Street Address	City and State		Zip Code		Home Phone #
Patient's Employer (if child, go to next line)	Address		Work Phone#		Cell Phone #

Spouse's Name	Birth Date	SS#
Spouse's Employer and address	Work Phone #	Cell Phone #

Father's Name (if patient is a child)	Address	SS#
Father's Employer and address	Work Phone #	Cell Phone #
Mother's Name (if patient is a child)	Address	SS#
Mother's Employer and address	Work Phone #	Cell Phone #

Primary Care Physician	Address	Phone #
Referring Physician	Address	Phone #
How did you hear about our practice?	Drug Allergies:	

Name of Nearest Relative/Friend not listed	Address	Phone #

PAYMENT AND INSURANCE INFORMATION				
Name of Primary Insurance	Policy Holder	Birth Date	Policy or ID #	Group #
Name of Secondary Insurance	Policy Holder	Birth Date	Policy or ID #	Group #
Name of Third Insurance	Policy Holder	Birth Date	Policy or ID #	Group #

INSURANCE AUTHORIZATION, ASSIGNMENT, AND ACKNOWLEDGEMENT:

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for co -pays and deductibles when services are rendered unless other arrangements have been made in advance. Name of Policy Holder ____I request that payment of authorized Insurance Company benefit be made either to me or on my behalf to Allergy & Immunology, P.L.C. for any services furnished me by this office. Regulations pertaining to Medicare assignment of benefits apply. I further understand that if my account has to be turned over to a Collection Agency for collection, I will be responsible for any additional collection fees. I further understand that I will be responsible for any fees associated with medical records being released for transfer of care, applying for new insurance, disability benefits, or other medical forms.

Signature____Date______________