Allergy & Asthma Associates
New Patient Registration

Patient Information

Patient Name: _____ DOB: _____
First Middle Last

Home Address: _____
City State Zip Code

Age: _____ Male Female
(circle one)

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

E-mail address: _____ Marital Status: Married Single Divorced Widowed
(circle one)

Responsible Party (primary insurance holder)

Responsible Party Name: _____ DOB: _____
First Middle Last

Home Address: _____
City State Zip Code

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

Relationship to Patient: _____ Male Female
(circle one)

SS# of policy holder: _____ Employer: _____
(must have to file insurance claim) (must have to file insurance claim)

How were you referred to Allergy & Asthma Associates?

Referring Physician Phone Directory Newspaper Postcard Friend Website Insurance Plan Other
(circle one)

Specific name of referral source: _____

Have you read our Newsletter? Yes No (circle one) Have you visited our website at www.texallergy.com? Yes No (circle one)

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

In case of Emergency, Notify:
Name: _____ Relationship: _____ Phone #: _____

Miscellaneous Information

Primary Care Physician/Pediatrician: _____ Phone #: _____

Have you or a member of your family been here before? Yes No
(circle one)

If yes, patient name: _____ Relationship: _____

Assignment of Benefits: I hereby authorize payment to any physician of Allergy & Asthma Associates who has treated my dependents or me for medical services rendered. I understand that I am financially responsible for all services not covered by my insurance company. I also understand that if I do not give a minimum of 48 hours notice for cancellation of allergy skin testing appointments, I will be billed a $52 cancellation fee that is not covered by my insurance. Failure to cancel office visit appointments at least 24 hours prior to appointment will result in a $30 charge.

Signature: _____ Date: _____

Release of Information: I hereby authorize the physicians of Allergy & Asthma Associates to release my information required to process any claims for my dependents or me. Signature: _____ Date: _____

We make every effort to contact your insurance company and verify your benefits. However, verification of insurance benefits is not a guarantee of payment until claims are submitted and the insurance company reviews all records. If your insurance company denies payment or services are not covered, you will become financially responsible for services. Please be aware that if you participate in an HMO and need a referral for this visit or any other services,

IT IS YOUR RESPONSIBILITY TO MAKE SURE WE HAVE THE REFERRAL IN OUR OFFICE BEFORE THE VISIT.

The office cannot be responsible for obtaining referrals.