

Adult Registration Form

Please Complete All Information * Please Type or Print Using Black Ink

Date _____

Patient's Name _____	Age _____
Address _____	City _____ State _____ Zip _____
Home Phone _____	Cell Phone _____
Birthdate _____	Gender _____ SSN _____
E-mail Address _____	
Employer _____	Work Phone _____

Spouse's Name _____	SSN _____	DOB _____
Home Address _____	City _____	State _____ Zip _____
Home Phone _____	Cell Phone _____	
E-mail Address _____		
Employer _____	Work Phone _____	

Insurance Information		
Primary Insurance Company _____	Policy Holder _____	
Relationship to Pt. _____	SSN _____	DOB _____
ID # _____	Group # _____	
Secondary Insurance Company _____	Policy Holder _____	
Relationship to Pt. _____	SSN _____	DOB _____
ID # _____	Group # _____	
Person Responsible for Bill _____	SSN _____	DOB _____
Relationship to Pt. _____	Home/Cell # _____	
Home Address _____	City _____	State _____ Zip _____

Physician Information			
Primary Care Physician _____	Phone _____	Fax _____	
Address _____	City _____	State _____	Zip _____
Referring Physician _____	Phone _____	Fax _____	
Address _____	City _____	State _____	Zip _____

I hereby authorize Allergy and Asthma Specialists to perform medicine reconciliation in order to assure my safety and the accuracy of my prescriptions.
Signature _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for payment of any professional services rendered and that payment is due and payable at time of service, unless arrangements have been made prior to my appointment.
Signature of Parent/Guardian _____

I authorize payment of medical benefits to Allergy and Asthma Specialists for services on all insurance claims submitted by them.
Signature of Parent/Guardian _____