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 Patient_____

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