Welcome to the Allergy and Asthma Clinic
Minor Registration Form

PERSONAL INFORMATION (PLEASE PRINT) DATE:________________________

PATIENT'S NAME: ______________________________ **GENDER:** ☐ **MALE** ☐ **FEMALE**

ADDRESS:______________________________**HOME PHONE:**______________________

CITY:____________________**STATE:**________ **ZIP CODE:**______________________

E-MAIL ADDRESS:________________________**CELL PHONE:**______________________

DATE OF BIRTH:____________________ **SOCIAL SECURITY #:**______________________

MOTHER'S NAME:___________________ **FATHER'S NAME:**________________________

GUARDIAN (if other than parent):____

DOES YOUR CHILD HAVE ANY DRUG ALLERGIES? ☐ **No** ☐ **Yes** __________________________

PEDIATRICIAN:____

ADDRESS:____

OTHER PHYSICIANS:____

IN CASE OF EMERGENCY, PLEASE CONTACT:__________________**RELATIONSHIP:**________

PHONE:____

INSURANCE INFORMATION

We will be happy to directly bill your insurance provider for your care. Please remember that you are financially responsible for all the costs of your care, regardless of your insurance coverage.

RESPONSIBLE/INSURED PARTY:________________**RELATIONSHIP:**____________________

EMPLOYER:___________________**SOCIAL SECURITY #:**____________________________

EMPLOYER ADDRESS:____

EMPLOYER PHONE #:____

PAYMENT AND RELEASE AUTHORIZATION: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits or directly billed insurance payments to the Allergy and Asthma Clinic/Andrew C. Engler, M.D. for services provided. I understand that I am financially responsible for entire charges, whether or not they are covered by my insurance.

I hereby authorize this healthcare provider to release all the information necessary to secure the payments of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

RESPONSIBLE PARTY:________________________**DATE:**____________________________
SIGNATURE