Welcome to the Allergy and Asthma Clinic

PERSONAL INFORMATION (PLEASE PRINT) **DATE:** _____

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

ADDRESS: _____ **HOME PHONE:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

E-MAIL ADDRESS: _____ **CELL #:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____

EMPLOYER: _____ **OCCUPATION:** _____

WORK ADDRESS: _____

WORK PHONE: _____

DO YOU HAVE ANY DRUG ALLERGIES? ☐ **No** ☐ **Yes** _____

REFERRING PHYSICIAN: _____ **ADDRESS:** _____

CURRENT PHARMACY:

_____

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.

INSURANCE: _____ **GROUP #:** _____ **INSURANCE ID:** _____

RESPONSIBLE/INSURED PARTY: _____ **RELATIONSHIP:** _____

EMPLOYER: _____ **SOCIAL SECURITY #:** _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE #: _____

SECONDARY INSURANCE: _____ **GROUP #:** _____ **INSURANCE ID:** _____

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 the 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.

Patient/Responsible Party Signature: _____ **DATE:** _____