Allergy, Asthma & Sinus Center, PC

Patient's Name_____ Age_____
(First) (MI) (Last)

Address_____

City, State, Zip_____

Home # (____)_____ Cell #(____)_____ Date of Birth ____/____/____ Sex M F

o Married o Single o Divorced

SSN _____ Work#(____)_____ o Separated o Widowed o Other

o Student o Employed o Unemployed

Race _____ Ethnicity _____ Language _____

E-mail address_____

How did you hear about us? _____

Primary Care Physician_____ Phone # (_____)_____

Referring Physician_____ Phone # (_____)_____

Pharmacy _____**Location**_____Phone # (_____)_____

Primary Insurance_____ Phone # (_____)_____

ID # _____ Group # _____

Name of Policy Holder_____Relationship_____

Policy Holder's Social Security _____ Date of Birth_____

Responsible/"Bill To" Name _____

Secondary Insurance_____Phone # (_____)_____

ID # _____Group # _____

Name of Policy Holder_____Relationship_____

Policy Holder's Social Security_____ Date of Birth_____

I hereby authorize Allergy, Asthma and Sinus Center to release the information requested to the insurance company named hereon. I hereby assign payment directly to the above named Physician of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I agree that in the event that my account must be turned over to an attorney/collection agency, that I will be responsible for collection fees, attorney fees, court costs, and interest. **I AM AWARE THAT I WILL BE CHARGED A $45 FEE FOR ANY APPOINTMENT THAT IS MISSED/CANCELLED WITHOUT GIVING US A 24 HOUR NOTICE.**

Signature_____ **Date**_____
Patient/Guardian Signature