Allergy, Asthma & Sinus Center, PC

Patient's Name____Age________
(First) (MI) (Last)
Address____

City, State, Zip____

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

SSN ________________________ Work#(____)______________

o Married o Single o Divorced
o Separated o Widowed o Other

o Student o Employed o Unemployed o Retired

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

Revised 9/2/20