Allergy and Asthma Specialty Center, Inc.
New Patient Registration Form

PATIENT INFORMATION

Date | Full Legal Name (First) (Middle) (Last) | Nickname

Address | Apt # | City | State | Zip Code

Email | Home Phone | Work Phone | Cell Phone

Social Security Number | Gender | Marital Status | Date of Birth | Driver's License No. | State issued

Employer Name | Employer Address | Spouse Name and Phone number

Permitted contact methods: Home___ Work___ Cell___

Referring Physician and Phone # _____ How did you hear about us?_____

PLEASE COMPLETE IF PATIENT IS UNDER 18 OR INSURED BY PARENT

Mother Full Legal Name | Phone# | Address

Father Full legal Name | Phone# | Address

INSURANCE INFORMATION

Primary Insurance Company Name | Group Number | ID/Contract Number

Policy Holder's Name/Parent Name (if child) | Date of Birth | Policy Holder's Social Security Number

Secondary Insurance Company Name | Group Number | ID/Contract Number

Secondary Policy Holder's Name | Date of Birth | Policy Holder's Social Security Number

Person to Notify in Case of Emergency | Relationship | Home Phone | Cell Phone

Pharmacy | Pharmacy Address | Pharmacy Phone Number

I request that payment of authorized benefits be paid to Allergy and Asthma Specialty Center, Inc., for services furnished to me by one of their providers. I hereby authorize them to bill my insurance company, realizing that I am responsible to pay non-covered services. I also authorize release of pertinent medical information to my insurance carrier.

Signature of patient/Guardian | Date