asthma : allergy center

PATIENT INFORMATION FORM

PATIENT'S NAME
(LAST) _____ (FIRST) _____ D.O.B _____

SOCIAL SECURITY # _____ CELL # _____

EMAIL _____ ADDRESS _____

APT# _____ CITY/STATE/ZIP _____

EMPLOYER NAME _____ADDRESS_____
CITY/STATE/ZIP _____ _____WORK TEL _____X_____ _

- Referring Doctor (if applicable) _____ Phone #_____
  Address_____ City/State/Zip_____ _____
- Your Primary Doctor (if applicable) _____ Phone #_____
  Address_____ City/State/Zip_____

NAME OF SPOUSE/PARENT/LEGAL GUARDIAN _____
EMPLOYER_____ADDRESS_____
CITY/STATE/ZIP _____ _____WORK TEL _____X _____

- PRIMARY MEDICAL INSURANCE (INSURANCE EFFECTIVE DATE _____)
NAME OF INSURANCE COMPANY_____ _____PHONE #_____
PLAN TYPE _____ ID#_____ GROUP #_____
POLICY HOLDER NAME (LAST)_____ (FIRST) _____
POLICY HOLDER D.O.B _____ ADDRESS_____
CITY/STATE/ZIP_____ RELATIONSHIP_____
POLICY HOLDER SS #_____ EMPLOYER _____

- SECONDARY MEDICAL INSURANCE (INSURANCE EFFECTIVE DATE _____)
NAME OF INSURANCE COMPANY_____ _____PHONE #_____
PLAN TYPE _____ ID#_____ _____GROUP #_____
POLICY HOLDER NAME (LAST)_____ (FIRST) _____
POLICY HOLDER D.O.B _____ ADDRESS_____
CITY/STATE/ZIP_____ RELATIONSHIP_____
POLICY HOLDER SS #_____ EMPLOYER _____

I WILL BE PAYING BY: [ ] CASH [ ] CHECK [ ] CREDIT CARD

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical information or other information necessary to process my claim, or to another physician if needed.

Signed _____ Date _____

I hereby authorize and request that payment of this claim for services rendered be made directly to Asif Khan, MD (Asthma and Allergy Center Ltd.). I understand that this bill may be submitted electronically (by computer) and give my permission to do so. If my insurance carrier should send me a check for today's visit, I will endorse Asif Khan, MD (Asthma and Allergy Center Ltd.) and forward it promptly.

Date: _____ PATIENT'S SIGNATURE: _____

IF MINOR, NAME OF RESPONSIBLE PARTY_____

SIGNATURE OF RESPONSIBLE PARTY _____