

Allergy Partners Patient and Insurance

Please Fill Out Completely:

Patient's Name:	_____ 85622 _____	SSN: _____
Date of Birth:	_____ Age: _____	Referred By ___ Friend/Relative ___ Yellow Pages ___ Newspaper Ad ___ Physician _____
Patient's Address:	_____	_____
Patient's Phone (Primary):	_____ Other _____	Patient's Phone (Secondary): _____ Other _____
Marital Status:	[] Married [] Single [] Divorced	Sex: [] M [] F
Employer:	_____	Employer Phone: _____

Responsible Party:	_____ 94934 _____	Date of Birth: _____
Resp. Party Address:	_____	_____
Resp. Party Phone:	Primary _____	Secondary _____
Emergency Contact Name:	_____	Emergency Contact Relationship: _____
Phone:	_____	Email Address: _____

Referred By: _____

Is this visit related to a car accident?

Yes No

Employment:

Employed Full-Time

Is this visit related to a work injury?

Yes No

Retired

Date of Accident or Injury: _____

Currently Unemployed

Primary Insurance Information

Primary Insurance Co.:	_____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Member Name:	_____	Member ID No.: _____
Group Number:	_____	Group Name: _____
Relationship:	_____	
SSN:	_____	Date of Birth: _____

Secondary Insurance Information

Secondary Insurance Co.:	_____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Member Name:	_____	Member ID No.: _____
Group Number:	_____	Group Name: _____
Relationship:	_____	
SSN:	_____	Date of Birth: _____

List Any Persons to Whom You Will Allow Access Of Your Medical Records

Name: _____ Relationship to Patient: _____

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I hereby authorize the office of Allergy Partners, PA to release any information necessary to process any insurance claim for services rendered. I hereby authorize payment from my insurance company or governmental payor to pay directly to Allergy Partners, PA for services rendered. Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered.

I acknowledge that I have received a copy of Allergy Partners, P.A. Notice Regarding Privacy of Personal Health Information (PHI). I understand that Allergy Partners, PA may request a medication history from my pharmacy as part of my treatment plan, and I hereby give my consent for such request.

Signature _____ Signature: _____ Date _____

Patient

Responsible Party

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