

PATIENT INFORMATION

INSTRUCTIONS: Please be sure to fill out all the requested information - PLEASE PRINT

PATIENT NAME: (LAST) (FIRST) (MIDDLE)			MARITAL STATUS: (CIRCLE) S M D W SEP		SEX: (CIRCLE) MALE FEMALE	
ADDRESS:			APT. #:	CITY:	STATE:	ZIP:
HOME TEL. #: ()		CELL. TEL. #: ()		WORK #: ()		EXT.
DATE OF BIRTH:			AGE:	SOCIAL SECURITY #:		
NAME OF EMPLOYER OR SCHOOL:						
NAME OF PRIMARY CARE PHYSICIAN/PEDIATRICIAN:			PHARMACY NAME:		PHARMACY TEL. # ()	
HOW DID YOU HEAR ABOUT ASTHMA & ALLERGY?	REFERRING PHYSICIAN (FULL NAME):		FAMILY/FRIEND (FULL NAME):		INTERNET/OTHER:	

IF PATIENT IS A MINOR OR STUDENT/EMERGENCY CONTACT

MOTHER'S NAME:			DATE OF BIRTH:		SOCIAL SECURITY #:	
ADDRESS (IF DIFFERENT):			APT. #:	CITY:	STATE:	ZIP:
HOME TEL. #: ()		CELL TEL. #: ()		MARITAL STATUS: (CIRCLE) S M D W SEP		
EMPLOYER:			OCCUPATION:		WORK TEL. #: ()	
FATHER'S NAME:			DATE OF BIRTH:		SOCIAL SECURITY #:	
ADDRESS (IF DIFFERENT):			APT. #:	CITY:	STATE:	ZIP:
HOME TEL. #: ()		CELL TEL. #: ()		MARITAL STATUS: (CIRCLE) S M D W SEP		
EMPLOYER:			OCCUPATION:		WORK TEL. #: ()	

**INSURANCE CARD INFORMATION: INSURANCE AS IT APPEARS ON YOUR CARD
(Please provide a copy of insurance card and photo identification)**

PRIMARY INSURANCE COMPANY:		PRIMARY POLICY HOLDER:	
PRIMARY INSURANCE ID #:		GROUP #:	
SECONDARY INSURANCE COMPANY:		PRIMARY POLICY HOLDER:	
SECONDARY INSURANCE ID #:		GROUP #:	

RELEASE AND ASSIGNMENT

I HEREBY AUTHORIZE Asthma and Allergy Associates of Florida, P.A. to release to your Company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care.

I authorize the doctors, nurses or employees of Asthma and Allergy Associates of Florida, P.A. to call my home and leave a detailed message. I also understand that I am solely responsible for any outstanding balance or bill not covered or paid by my insurance company.

I also assign, transfer and set over to Asthma and Allergy Associates of Florida, P.A. all my rights, title and interest to my medical reimbursement benefits under my insurance policy with your company. I also understand that I am solely responsible for any outstanding balance or bill not covered or paid by my insurance company.



PATIENT/GUARANTOR'S SIGNATURE

DATE