

NEW PATIENT RECORD**ACCOUNT #** _____PATIENT: _____ DOB: _____ SEX: Male Female
(LAST) (FIRST) (MI)ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

HOME # (_____) _____ CELL # (_____) _____ Social Security # _____

CHECK ONE: MINOR SINGLE MARRIED DIVORCED WIDOWED E-MAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____ WORK # (_____) _____

IF PATIENT IS UNDER 18RESPONSIBLE PARTY: _____ DOB: _____ SSN: _____
RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____ WORK # (_____) _____

INSURANCE INFORMATION**PRIMARY INSURANCE:** _____ **POLICY HOLDER'S NAME:** _____

DOB: _____ SSN: _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____ WORK # (_____) _____

SECONDARY INSURANCE: _____ **POLICY HOLDER'S NAME:** _____

DOB: _____ SSN: _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____ WORK # (_____) _____

FAMILY DOCTOR: _____ PHONE: (_____) _____

ADDRESS: _____

WERE YOU REFERRED TO OUR OFFICE? YES NO BY WHOM? ANOTHER PATIENT PHYSICIAN OTHER _____

REFERRING DOCTOR: _____ PHONE: (_____) _____

ADDRESS: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE ALLERGY ASTHMA CLINIC, LTD. TO RELEASE ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO ALLERGY ASTHMA CLINIC, LTD. FOR MEDICAL CARE RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND I AM RESPONSIBLE FOR AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE: _____ DATE: _____