PLEASE FILL OUT COMPLETELY - (Please Print)

Date _____ ***(Required)Home Phone#**_____

-- PATIENT INFORMATION --

Name_____Soc. Sec. # _____
Last Name First Name Initial

Address_____**Mobile Phone#**_____

City_____ State _____ Zip_____

Sex ☐M ☐F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____**Business Phone**#_____

Business Address_____Occupation_____

Referred By _____ Family Physician_____

In case of emergency who should be notified? _____**Alternate Phone#**_____

-- PRIMARY INSURANCE --

Policy Owner _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec.# _____

Address (if different from patient's) _____ **Phone#**_____

City _____ State _____ Zip _____

Policy Owner Employed by _____ Occupation_____

Business Address _____ **Business Phone#** _____

Insurance Company _____ Address _____

ID # _____ Group # _____ Phone # _____

-- ADDITIONAL INSURANCE --

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to patient _____ Birthdate _____

Address (if different from patient's) _____ Phone_____

City _____ State _____ Zip _____

Subscriber Employed by_____ Business Phone _____

Insurance Company _____ Address _____

ID # _____ Group # _____ Phone # _____

-- ASSIGNMENT AND RELEASE --

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

And assign directly to Alamo Asthma & Allergy Associates, P.A.all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I UNDERSTAND THAT IF A REFERRAL IS REQUIRED BY MY INSURANCE COMPANY IT IS MY RESPONSIBILTY TO OBTAIN ONE FROM MY FAMILY PHYSICIAN.

_____ _____ _____
Responsible Party Signature Relationship/ Social Security Number Date