

Welcome to our office. We must have complete and accurate information from you in order to provide you with the best medical care and service. ***** PLEASE PRINT CLEARLY! *****

*** Please give all of your **MEDICAL INSURANCE IDENTIFICATION CARDS** to our receptionist so that we can copy them.

Patient's
Legal Name: _____
Last First Middle

Address: _____
Street / Apt. # / P.O. Box City State Zip

Home Telephone: (_____)
>>>Patient's Sex
>>>>(Circle One): Male Female

Marital Status
>>>>(Circle One): Single Married Divorced Widowed Patient's Date of Birth: _____ Age: _____

Referred to us by: _____ Family Physician: _____

Patient's Social Security #: _____ Cell Telephone (_____)

Patient's Employer: _____ Work Phone: (_____)

Spouse's Legal Name: _____
Last First Middle

Spouse's Social Security #: _____ Spouse's Date of Birth: _____ Age: _____

Spouse's Employer: _____ Work Phone: (_____)

Primary Insurance Co.: _____ Name of Insured _____

Cert or Insured I.D. # : _____ Policy or Group # : _____

Secondary Insurance Co.: _____ Name of Insured _____

Cert or Insured I.D. # : _____ Policy or Group # : _____

Relative not living with you: _____ Phone: (_____)

Are You? : (A) Under 18 years old or (B) Under 23 years old & a Student *** Circle appropriate choice ***

If (A) or (B) applies to you, then you must provide us with complete parent/guardian information. Please ask our receptionist for a Parent/Guardian Information Form.

I have completed these forms to the best of my ability and they are correct. I understand I am responsible for full payment of any and all services. I authorize the release of any medical or other information necessary to process any insurance claims. I request and authorize payment of any benefits from any insurance or medical plan, including those listed above or attached, to Southern Allergy & Asthma, P.C.

Signature of Patient/Authorized Person Date