COMPREHENSIVE ALLERGY & ASTHMA CARE CENTER

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's Last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Birth date: / /	**Age:**	**Sex:** ❑ M ❑ F	Home phone no. ( )		Mobile phone no.
Street address:					SS number:
P.O. box:	City:		State:		ZIP Code:
Occupation:	Employer:				Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Primary Care Physician/Address/Phone Number:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):			Home phone no.: ( )
Occupation:	Employer:	Employer address:			Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*