Allergy Asthma and Sinus Centers

# Patient Registration Form — Patient Information

## Patient Information

*Please complete in BLOCK CAPITALS*

Full Name

Social Security Number

Date of Birth
[ M M ] - [ D D ] - [ Y Y Y Y ]

Sex
[ X ] Male [ X ] Female

Marital Status
[ X ] Minor [ X ] Married [ X ] Divorced [ X ] Separated [ X ] Widowed [ X ] Single

Home Address

City

State

ZIP

Ethnicity
[ X ] Hispanic [ X ] Non-Hispanic

(If Hispanic) Preferred Language

Home Phone

Cell Phone

Alternative Phone Number

Work Phone Number

Email Address

Name of Employer

Employer's Address

Employer's City

Employer's State

Employer's ZIP

## Emergency Contact

*Please complete in BLOCK CAPITALS*

Full Name

Phone

## Primary Care Physician

*Please complete in BLOCK CAPITALS*

Full Name

Phone

Fax

## Responsible Party (Parent or Guardian)

*Please complete in BLOCK CAPITALS*

*If this info is same as above, please list self.*

Full Name

Social Security Number

Relationship to Patient

Home Address

City

State

ZIP

Date of Birth
[ M M ] - [ D D ] - [ Y Y Y Y ]

Home Phone

Cell Phone

Alternative Phone Number

Work Phone Number

Email Address

Name of Employer

Employer's Address

Employer's City

Employer's State

Employer's ZIP

## Referrals

*Please complete in BLOCK CAPITALS*

Who may we thank for referring you?

If referred by physician, please leave their phone no.

## Spouse of Responsible Party

*Please complete in BLOCK CAPITALS*

Full Name

Social Security Number

Relationship to Patient

Home Address

City

State

ZIP

Date of Birth
[ M M ] - [ D D ] - [ Y Y Y Y ]

Home Phone

Cell Phone

Alternative Phone Number

Work Phone Number

Email Address

Name of Employer

Employer's Address

Employer's City

Employer's State

Employer's ZIP

## Insurance Information (Policy Holder)

*Please complete in BLOCK CAPITALS*

Full Name of Insured

Social Security Number

Relationship to Patient

Home Address

City

State

ZIP

Date of Birth
[ M M ] - [ D D ] - [ Y Y Y Y ]

Home Phone

Cell Phone

Alternative Phone Number

Work Phone Number

Email Address

Name of Employer

Employer's Address

Employer's City

Employer's State

Employer's ZIP

Name of Insurance

[ X ] HMO [ X ] PPO [ X ] EPO [ X ] Other

## Additional Insurance (Where Applicable)

*Please complete in BLOCK CAPITALS*

Full Name of Insured

Social Security Number

Relationship to Patient

Home Address

City

State

ZIP

Date of Birth

[ M M ] - [ D D ] - [ Y Y Y Y ]

Home Phone

Cell Phone

Alternative Phone Number

Work Phone Number

Email Address

Name of Employer

Employer's Address

Employer's City

Employer's State

Employer's ZIP

Name of Insurance

[ X ] HMO [ X ] PPO [ X ] EPO [ X ] Other

I authorize the details of any healthcare, advice and treatment given to myself (or my child) to be released to my (or my child's) referring physician as well as to the insurance company for the purpose of evaluating and administrating claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. **I understand that my insurance company is being billed as a courtesy to me. Any benefits not paid by my insurance company will be my responsibility to pay.** If unable to keep appointment, kindly give 24 hour notice or a fee will be charged.

**X** SIGNATURE OF PATIENT (PARENT IF A MINOR) **DATE:** MM - DD - YYYY