ALLERGY, ASTHMA & IMMUNOLOGY INSTITUTE

PATIENT DEMOGRAPHIC RECORD

PATIENT: ______________________________ DOB: ____________
(Last) (First) (M.I.)

ADDRESS: ____
(Street) (City) (State) (Zip Code)

PHONE: ____________________

MARITAL STATUS:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home #: ____________________

Work #: ____________________

GENDER:

☐ Male ☐ Female

Cell #: ____________________

Emergency #: ____________________ SSN: ____________________

EMPLOYER: ____

OCCUPATION: ____________________ EMAIL: ____________________

PRIMARY PHYSICIAN: ______________________ Phone: ____________

Address: ______________________________ Fax: ____________

REFERRED BY: ______________________________ Phone: ____________

RESPONSIBLE PARTY: ____________________ SSN: ________ DOB: ________
(IF PATIENT IS A MINOR)

Employer: ______________________________ Work #: ____________

PRIMARY INSURANCE: ______________________ PHONE #: ____________

Claims Address: ____

MEMBER ID #: ______________________ GROUP #: ____________

Policy Holder: ______________________ SSN: ________ DOB: ________

SECONDARY INSURANCE: ______________________ PHONE #: ____________

Claims Address: ____

MEMBER ID #: ______________________ GROUP #: ____________

Policy Holder: ______________________ SSN: ________ DOB: ________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS:

I hereby authorize Allergy, Asthma & Immunology Institute, to release any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to Allergy, Asthma & Immunology Institute, for medical care rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance, and I will check my own insurance benefits for allergy care. I acknowledge that I have received and understand the HIPAA Notice of Privacy Practices.

SIGNATURE: ______________________________ DATE: ____________