Juan L. Sotomayor, MD, PC
ALLERGY & ASTHMA
Diagnostic Office

Patient Registration Form

Today's Date_____ Primary Care Physician_____Referring Physician_____
Reason for visit: _____
Have you been prescribed or do you use an inhaler or nebulizer? YES NO

Preferred contact/cell#:_____ This number is able to receive texts: Y N
Preferred communication email:_____
As a courtesy, we send appointment reminders to your preferred phone number and email. Ultimately, patients are responsible for keeping track of their scheduled appointments.

PATIENT FIRST NAME_____MIDDLE_____LAST NAME_____
DOB_____Marital status: S M D W Sex: M F Full-time student: Y N PT
Mailing address_____City_____State_____Zip code_____
Occupation_____Name of Employer/Business_____Work phone#_____
Employer's address_____City_____State_____Zip code_____
Emergency contact name_____Relationship_____Phone#_____
_____

Please complete all insurance information below, in addition to providing a copy of your insurance ID card at each visit, so we can add it to your electronic medical record. Thank you for your anticipated cooperation!
**PLEASE INITIAL HERE IF YOU DO NOT HAVE A SECONDARY INSURANCE_____

Primary Insurance
Insurance Co_____Effective date_____
ID#_____Grp#_____
Referral Required? Y N
Policy Holder Name & Address (if different from above):
_____
DOB_____Relationship to patient_____
Employer_____Occupation_____
_____

Secondary Insurance
Insurance Co_____Effective date_____
ID#_____Grp#_____
Referral Required? Y N
Policy Holder Name & Address (if different from above):
_____
DOB_____Relationship to patient_____
Employer_____Occupation_____

Parent/Legal Guardian Information (If patient is less than 18 years old, please fill out all information below)
Name_____DOB_____Sex: M F Lives with child: Y N
Address (if different from above)_____City_____State_____Zip code_____
Phone#_____Email_____
Employer_____Employer phone#_____Occupation_____
Name_____DOB_____Sex: M F Lives with child: Y N
Address (if different from above)_____City_____State_____Zip code_____
Phone#_____Email_____
Employer_____Employer phone#_____Occupation_____
_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES & PATIENT BILL OF RIGHTS The Allergy & Asthma Diagnostic Office has posted their "Notice of Privacy Practices" and Patient's Bill of Rights & Responsibilities in the patient waiting room and on their website at www.allergyaway.com. I understand that upon request, I am entitled to receive a paper copy at any time. I understand the Allergy & Asthma Diagnostic Office reserves the right to change the privacy practices policy to remain in compliance with HIPAA Regulations.
REQUEST FOR SERVICE AUTHORIZATION I hereby authorize providers of the Allergy and Asthma Diagnostic Office to furnish medical services to me and consent to the performance of any diagnostic studies and medical treatment as discussed and mutually agreed to (or, if I am executing this agreement as a parent or legal guardian of a child). I hereby authorize the release of any medical information necessary to process any claims to my insurance carrier regarding this and subsequent visits to this office. I certify that the information given by me in applying for payment by my insurance company is correct and that I will notify AADO with any changes in medical insurance. I authorize and request that payment of benefits by my insurance carrier be made directly to the AADO for services furnished to me or my dependent. I further understand that I may be responsible for all charges not covered by this assignment. PLEASE NOTE: It is necessary that all requested information be completed prior to treatment. This form will need to be completed annually and when any change in information occurs. Our office will submit to your insurance carrier providing we have all the necessary information, otherwise payment in full may be requested at the time of service. ALL CO-PAYMENTS ARE PAYABLE AT THE TIME OF SERVICE; otherwise a $20.00 billing charge will automatically be added to your account. Thank You. I have read the above certification, or it has been read to me, and I fully understand and agree to the above in its entirety.

_____ _____ _____ _____
Printed name of patient/legal guardian Date Signature of patient/legal guardian Date