

**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 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.*

Billing statement preference: \_\_\_\_\_ Email \_\_\_\_\_ Text \_\_\_\_\_

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!

**\*\*YOU MUST FILL OUT BELOW INFORMATION EVEN IF WE HAVE YOUR CURRENT INSURANCE CARD\*\***

**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