ASTHMA and ALLERGY INSTITUTE

ADMINISTRATIVE HISTORY

Patient Information Today's Date: _____

Name: _____ Email: _____

Address: _____ City: _____ State: _____

Zip Code: _____ ( ) Male ( ) Female Date of Birth: _____/_____/_____

Race: _____ Ethnicity: _____ Language: _____ SS #: _____ - ____ - _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Other

Home Telephone: (____) _____-_____ Cell Telephone: (____) _____-_____

Employment: _____ Work Phone: (____) _____-_____

Spouse Name: _____

Address **(if different)** _____ City _____ St _____ Zip _____

Legal Guardian **(if patient's under 18):** Name: _____
Address: _____City: _____ St: _____ Zip _____
Relation To Patient: _____ Contact Phone #: (___) _____-_____

Financial Responsibility

Name: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Place of Employment: _____ Work Phone:(____)_____-_____

Insurance Information
(Please provide your card to copy. We must have a copy in order to file with your insurance company.)

Insurance Company or Plan Name: _____

Insured's Name(If different from financially responsible person): _____

Policy Holder Date of Birth: _____/_____/_____ Relation to Patient: _____

Contract or Member ID: _____ Group Number: _____

Insurance Information Continued:

Secondary Insurance ( ) Yes ( ) No Policy Holders Name: _____

Insurance Company or Plan Name: _____

Insured's Name(If different from financially responsible person): _____

Policy Holder Date of Birth: _____/_____/_____ Relation to Patient: _____

Contact or Member ID: _____ Group Number: _____

Primary Care Physician: _____ City: _____ State: _____

Referring Physician: _____ City: _____ State: _____

Emergency Contact:

Name: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone: (___) _____-_____ Cell Phone: (___) _____-_____

Work Telephone: (___) _____-_____ Other Phone: (___) _____-_____

How did you hear about us?

( ) Family Member ( ) Friend ( ) Physician ( ) Phone Book ( ) Radio

( ) Newspaper ( ) Other Advertisement ( ) Insurance Company

( ) Other (please indicate) _____

I/we, the undersigned, give prior express consent to The Asthma & Allergy Institute, its employees and/or agents to contact me at any/all phone numbers, including cell phone numbers, for the purpose of treatment, insurance, and/or payment.

By signing this form, I certify that the above information is correct.

Patient/Guardian Signature: _____

Date: _____