Allergy/Asthma Specialists W. MI

Board Certified Pediatric and Adult Allergy-Immunology
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Patient Registration Form
Welcome To Our Office! To assist us in your care, please fill out all areas of this form which apply to you. Thank You!

Patients Name: _____Sex: M / F
First **Middle** **Last**
Home Address: _____ City: _____
State: _____ Zip: _____ Birthdate: _____
SSN: _____Home: ( )_____Work #: ( )_____
Cell Phone: _____ Preferred # Home _____Work _____ Cell _____
Email (for patient surveys): _____
Marital status: S M W D

IS THIS A REFERRAL VISIT? Yes or No
IF NOT REFERRED BY A PRIMARY CARE PROVIDER: Do you want us to send a letter to the primary care provider? **Yes** or **No** (circle one)
NAME OF PRIMARY CARE PROVIDER: _____
Address or Phone: _____
PREFERRED PHARMACY: _____
Address or Phone: _____

How did you learn about our practice? _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____
(complete if address is different)
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( )_____Email:_____

PRIMARY INSURANCE
Name of Insurance Company: _____ Phone #: _____
Policy Holder's Name: _____ P.H. Birthdate: _____
Group #: _____ Policy ID: _____ SSN#: _____
Policy Holder's Address(if different): _____
City: _____ State: _____ Zip: _____ P.H. Phone#_____
Employer: _____ Employer Phone #: _____
Emplyment Status: Full Time: ____ Part Time: ____

SECONDARY INSURANCE
Name of Insurance Company: _____ Phone #: _____
Policy Holder's Name: _____ P.H. Birthdate: _____
Group #: _____ Policy ID: _____ SSN#: _____
Policy Holder's Address(if different): _____
City: _____ State: _____ Zip: _____ P.H. Phone#_____
Employer: _____ Employer Phone #: _____
Emplyment Status: Full Time: ____ Part Time: ____

EMERGENCY CONTACT
(Someone who can get in touch with you if we cannot)

Contact: _____ Relationship: _____

Home Phone: ( ) _____Work Phone: ( ) _____Cell Phone: _____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co pay, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's Visit: ___Cash ___Check ___Visa/MC

Signature of Patient or Responsible Party: _____Date: _____

I request payment be made to Allergy/Asthma Specialists W. MI. The undersigned is responsible for all fees, regardless of insurance coverage. A copy of this authorization is as valid as the original.

Signed:
_____
(Patient or responsible party)

Date: _____

*****ONLY SIGN THIS SECTION IN OUR OFFICE AT CHECK-IN**

I acknowledge that I have received a copy of the Notice Regarding Privacy of Personal Health Information of Allergy/Asthma Specialists W. MI.

Signed:_____
(Patient or responsible party)

Date:_____