

SOUTHWEST ASTHMA AND ALLERGY ASSOCIATES P.A.

Personal and Insurance Information

Patient's Personal Information:

(PLEASE PRINT)

Today's Date: _____
Referring Physician _____
Patient's Date of Birth: _____
Male ___ Female ___

Last Name: _____ First Name: _____ Middle Initial _____

Ethnic Background: _____ Social Security # _____

Address Line 1: _____ Marital Status: ""Single "Married ""Divorced
""Widowed ""Separated

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone # _____ Cell Phone # _____ Email _____

Work # _____ Ext: _____ Employer's Name _____

Responsible Party: *(Statements and bills will be addressed to responsible party)*

Last Name: _____ First Name: _____ Middle Initial _____

Social Security # _____ Driver's License # _____
(Required)

Issuing State _____

***** *(Please fill in if different than Patient's)* *****

Address Line 1: _____ Marital Status: Single Married "Divorced
Widowed "Separated

Address Line 2: _____ Social Security: _____

City: _____ State: _____ Zip Code: _____

Home Phone # _____ Work or Cell Phone # _____ Email _____

Insurance Information:

Insured's Name: _____ DOB: _____ Male ___ Female ___

Relationship to patient: (circle one) Self Spouse Child Guardian Other _____

Insurance Company Name: _____ Group # _____

Group Name: _____ Employer: _____

Insurance ID number: _____ Member's Social Security # _____

Phone number for claims verification: area code () _____

Please see back of form

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***** If you have secondary insurance please complete this section *****

Insured's Name: _____ DOB: _____ Male ___ Female ___

Relationship to patient: (circle one) Self Spouse Child Guardian Other _____

Insurance Company Name: _____

Group Name: _____ Employer: _____

Insurance ID number: _____ Group # _____

Phone number for claims verification: area code () _____

Additional Information:

Emergency contact _____ Relationship _____ Phone # _____

Has any other family member been seen by one of our physicians? ___Yes ___No if yes, please state name and relationship to you. _____

If above named patient was a minor, may we ask the name of each parent:

Mother: _____ Father: _____

How did you hear about our practice and/or physician? _____

Please give us your Pharmacy Name: _____

Pharmacy Phone Number: _____ Fax Number: _____

Please read below and sign

I have had the opportunity to read/receive a copy of the privacy policy of Southwest Asthma and Allergy Associates and hereby authorize any licensed physician, practitioner, hospital, clinic or other medical facility or its representative to release any and all information with respect to any illness or injury, medical history, consultation, prescription(s) or treatment and copies of all medical records to : The physicians of Southwest Asthma and Allergy Associates, I also authorize Southwest Asthma and Allergy Associates, its physicians and providers to release medical records to the insurance company that is responsible for my health coverage should it be necessary for payment of services provided.

Signature: _____ Date: _____

* This authorization is good for one year from date of Signature

I hereby assign benefits and authorize payment to go directly to Southwest Asthma and Allergy Associates for any medical service provided, but not to exceed the reasonable and customary charges for these services. I agree that the doctor may receipt for any such payment and that his receipt shall be a conclusive acknowledgement by me that I have received benefits from the insurance company all the sum specified in such receipt and agree that such payment shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment. I understand that I am financially responsible to the doctor for all charges not covered by this agreement.

Signature: _____ Date: _____

This authorization is good for one year from date of Signature

A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.