

# Southwest Asthma & Allergy Associates

(Please Print)

Today's Date:		Primary Care Physician:			Referring Physician:		
PATIENT INFORMATION							
Patient's last name:				First:		Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Street address:			City:		State:	ZIP Code:	
Home Phone no: (    )		Cell Phone no.: (    )		Email:			
Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>			Social Security no.:	
Employer:			Employer phone no.: (    )		Ethnicity:		
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:							
If the above named patient was a minor, may we ask the name of each parent?			Mother:			Father:	

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist. Statements and bills will be addressed to responsible party.)							
Person responsible for bill:			Birth date:	Address (if different):		Home phone no.: (    )	
S.S. no.:			Driver's License no.:		Issuing State:		
Subscriber name:				Birth date of Insurance Subscriber:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Patient's relationship to insured:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of primary insurance:		Subscriber no.:		Group name:		Group no.:	
Employer:		Employer address:			Employer phone no.: (    )		
Name of Secondary Insurance (if applicable):		Subscriber name:		Birth date:	Subscriber no.:		
Patient relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY					
Emergency contact:		Relationship to patient:	Cell phone no.: (    )	Home phone no.: (    )	Work phone no.: (    )

ADDITIONAL INFORMATION			
Pharmacy Name:		Pharmacy phone no.: (    )	Pharmacy fax no.: (    )

## NOTIFICATION OF LIABILITY

I have had the opportunity to read/receive a copy of the privacy policy of Southwest Asthma & Allergy Associates and hereby authorize any licensed physician, practitioner, hospital, clinic or other medical facility or its representatives 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 physician's of Southwest Asthma & Allergy Associates. I also authorize Southwest Asthma & Allergy Associates, its physicians and providers to release medical records to the insurance company responsible for my health coverage should it become necessary for payment of services provided.

\_\_\_\_\_  
*Patient/Guardian signature*

\_\_\_\_\_  
*Date*

I hereby assign benefits and authorize payment to go directly to Southwest Asthma & Allergy Associates for any medical service provided but not to exceed the reasonable and customary charges for these services. This office is not responsible for incorrect benefit information given to us by your insurance carrier or for changes in coverage. A description of benefits is not a guarantee of coverage and cannot be relied on as such. In the event of non-payment by your insurance company the charges on your account will be your responsibility. I understand that I am financially responsible to the physician for all charges not covered by this agreement. Payment is due at time services are rendered. We accept Visa, Master Card, Discover, American Express, personal checks and cash for your convenience. Knowing your insurance benefits are the responsibility of the insured and dependents.

\_\_\_\_\_  
*Patient/Guardian signature*

\_\_\_\_\_  
*Date*

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