

**Patient Information  
(please print)**

sticker

PATIENT'S NAME \_\_\_\_\_

Address \_\_\_\_\_ LAST FIRST MIDDLE INITIAL

\_\_\_\_\_ STREET APT #

\_\_\_\_\_ CITY STATE ZIP Home Phone \_\_\_\_\_

Address Change \_\_\_\_\_

E-mail address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Social Security # \_\_\_\_\_

Other family members cared for by Allergy & Asthma Care and Prevention Center (AACPC): \_\_\_\_\_

Who referred you to AACPC? \_\_\_\_\_ If not referred, how did you find us? \_\_\_\_\_

Primary Care Physician (PCP) \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

Specialty Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

I give permission to AACPC to send a written report to my Doctors listed above.

Please complete for spouse. If the patient is a minor, please complete for both parents.

Policy Holder

Name \_\_\_\_\_

Relationship \_\_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ ext \_\_\_\_\_

E-mail address \_\_\_\_\_

Policy Holder

Name \_\_\_\_\_

Relationship \_\_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_

Phone \_\_\_\_\_ ext \_\_\_\_\_

E-mail address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ ext \_\_\_\_\_

**OUT OF TOWN PATIENTS:** Please provide local number where you may be reached: Phone \_\_\_\_\_

**BILLING PROCEDURE**

I authorize the release of any information necessary to process claims. I request payment of benefits to Allergy & Asthma Care and Prevention Center. I understand I am financially responsible for all charges relating to the care received. If my insurance fails to pay, for whatever reason, I am liable for any payment not made by such insurer. You will be charged the appropriate fees should your account be sent to a Collection Agency.

I understand and agree if care at Allergy & Asthma Care and Prevention Center requires Primary Care Physician referral, it is my responsibility to see that the referral is current prior to receiving care at Allergy & Asthma Care and Prevention Center. If no referral is present in advance, I agree to pay for charges at the time of service.

SIGNATURE \_\_\_\_\_

WITNESS \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

DATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**CONSENT FOR CARE OF MINORS**

Because my son/daughter is a minor (less than eighteen (18) years of age and primarily supported by parent or guardian), I understand and agree that he/she may be evaluated and/or treated by Allergy & Asthma Care and Prevention Center staff if I am not present to give consent. This may include but not necessarily be limited to physical exams, skin tests, blood and urine tests, allergy injections and the prescription of medications in my absence. This agreement will be in effect until revoked by me in writing.

SIGNATURE \_\_\_\_\_

WITNESS \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

DATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_