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PATIENT INFORMATION <i>(Please Print)</i>				DATE:			
PATIENT NAME	LAST	FIRST	MIDDLE	M	DATE OF BIRTH	/	/
				F			/
HOME ADDRESS		CITY		STATE		ZIP	
HOME PHONE		WORK PHONE		CELL PHONE			
SOCIAL SECURITY NUMBER		DRIVER'S LICENSE		STATE			
PATIENT OR PARENT'S EMPLOYER							
EMPLOYER'S ADDRESS				TELEPHONE			
OCCUPATION							
SPOUSE'S NAME				MARITAL STATUS		M S D W SEP.	
SPOUSE'S EMPLOYER							
SPOUSE'S EMPLOYER'S ADDRESS				TELEPHONE			
IN CASE OF EMERGENCY CONTACT				TELEPHONE			
REFERRED TO US BY				ADDRESS			
FAMILY DOCTOR OR GYN PEDIATRICIAN INTERIST				ADDRESS			
INSURANCE INFORMATION							
POLICY HOLDER'S NAME				DATE OF BIRTH		POLICY HOLDER'S SOCIAL SECURITY NUMBER	
PRIMARY INSURANCE COMPANY				POLICY NUMBER		GROUP NUMBER	
SECONDARY INSURANCE COMPANY				POLICY NUMBER		GROUP NUMBER	

I hereby authorize Allergy & Asthma Care, P.A., and its physicians to treat me/my child and to release any and all information to my insurance carrier for purposes of claims administration and evaluation, utilization review and financial audit. I also authorize release of information to my other physicians. These authorizations remain in effect from the date of signing until revoked in writing. I hereby assign to Allergy & Asthma Care, P.A. all money to which I am entitled for medical expense relative to services provided but not to exceed my indebtedness. It is understood that any money received from my insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to Allergy & Asthma Care, P.A. and its physicians for charges not covered by this assignment.

PARENT/GUARDIAN	/ /	DATE	PATIENT'S SIGNATURE	/ /	DATE
DATE			SIGNATURE		