

PATIENT INFORMATION

Patient's last name _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work _____ Mobile _____

Date of birth _____ Sex: Male ___ Female ___ Marital Status _____

Social security number _____ Employer _____

Emergency contact _____ Phone _____

Primary Physician _____ PCP Phone _____

Referring Physician _____ Ref Dr. Phone _____

Responsible Party if Patient is a Minor:

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work _____ Mobile _____

Social security number _____ Date of birth _____

Insurance Information

Primary _____ ID# _____ Group# _____

Policyholder _____ Date of birth _____

Social security number _____ Relationship to patient _____

Effective dates _____

Secondary _____ ID# _____ Group# _____

Policyholder _____ Date of birth _____

Social security number _____ Relationship to patient _____

Effective dates _____

*Authorization: I hereby authorize the physicians and representatives of Allergy and Asthma Specialists of Greater Washington to furnish medical treatment and provide information concerning my visits to my insurance carrier. I direct the insurer to pay any and all funds to Allergy and Asthma Specialists of Greater Washington directly. I am aware that I am personally responsible for all charges incurred during treatment whether covered by insurance or not. Co-payments and deductibles are due at the time of service. Patient or guarantor is responsible for all collection fees and costs for the collection of delinquent accounts. **HMO patients are responsible for securing and managing referral forms for their services.** Your signature below signifies your consent for treatment as well as your understanding of this payment policy.*

Signature of patient or responsible party _____ Date _____

How did you hear about our practice? _____

lease verify yearly by providing your initials and date on one of the lines below.
