ASTHMA ALLERGY CENTERS - **NEW PATIENT FORM**

First name ______ Street Address ______ Birth Date ______

Last Name ______ City ______ Age ______

Middle Name ______ State ______ Home Phone ______

Gender ☐ Male ☐ Female Zip Code ______ Work Phone ______

SSN ______ E-MAIL ______

Marital Status ______

Emergency Contact ______ Relationship ______ Employer ______ Phone ______

RACE ______ Ethnicity ______ Preferred Language ______

PLEASE FILL IN SECTION A & B IF PATIENT IS UNDER 18 (Or if insured by parent)

A. Father's Name ______ Employer ______

Address ______ Work Phone ______

City ______ State ______ Zip Code ______ SSN ______

B. Mother's Name ______ Employer ______

Address ______ Work Phone ______

City ______ State ______ Zip Code ______ SSN ______

Name of Primary Insurance ______ Subscriber's Name ______

Relationship to Patient ______ Date of Birth ______ SSN ______

Contract Number ______ Group Name ______ Effective Date ______

Address if Different ______ City ______ State ______ Zip Code ______

Name of Secondary Insurance ______ Subscriber's Name ______

Relationship to Patient ______ Date of Birth ______ SSN ______

Contract Number ______ Group Name ______ Effective Date ______

Address if Different ______ City ______ State ______ Zip Code ______

If any other insurance information, please document on other side of form

How did you hear about us? ☐ Radio / TV ☐ Friend ☐ Yellow Pages ☐ Doctor ☐ Other

Patient was referred by ______ Family Doctor ______

I request that payment of authorized benefits be made to Asthma Allergy Care Centers, P.L.C. for services furnished me by one of their physicians. I hereby authorize them to bill my insurance company, realizing that I am responsible to pay non-covered services. I also authorize release of pertinent medical information to my insurance carrier.

Patient or Parent Signature ______ Date Signed ______