ALLERGY, ASTHMA & SINUS CENTER, P.C.

Today's Date: ____________ Account No: ____________

Patient's Name ______________________________ Social Security # ____ – ____ – ____
Last First M.I.

Address ____
Street or P.O. City State Zip

Date of Birth ____________ Sex ______ Age ______ Home Phone: (____) ____________

Work Phone: (____) ____________ Cell Phone: (____) ____________

Whom May We Thank for Seeing You Today? ____________________

Other Contact Person (not @ same address) ____________ Home Phone (____) ____________

Family Physician: ____________ Referring Physician: ____________

I want the letter to be sent to (i) Dr. ____________ (ii) Dr. ____________

IF MINOR

Father's name ____________ Work Number (___)________ Cell No: ________

Mother's name ____________ Work Number (___)________ Cell No: ________

Person(s) Responsible for Account

Name ______________________________ Relationship to Patient ____________
Last First MI

Home Phone (____) ____________ Work Phone (____) ____________

Address ____
Street City State Zip

INSURANCE INFO

Primary Ins Company ____________________

Subscriber: ____________________

Subscriber Date of Birth ____________ **Sex** ______

Employer ____________________

Social Security # ____ – ____ – ____ **Relationship to Patient** ____________

ID# ____________ **Group#** ____________

Secondary Ins Company ____________________

Subscriber: ____________________

Subscriber Date of Birth ____________ **Sex** ______

Employer ____________________

Social Security # ____ – ____ – ____ **Relationship to Patient** ____________

ID# ____________ **Group#** ____________

Insurance Authorization / signature on File

I hereby authorize this office to furnish information to insurance carriers. I understand that I am responsible for any amount not covered by my insurance.

I have read and understand the above ______________________________
(signature) (date)

REORDER# 9620848