ALLERGY, ASTHMA, AND SINUS CENTER, P.C.

Dr. Agarwal M.D.
Board certified in Adult & Pediatric Allergy & Immunology

Patient Demographic Form

Today's Date _____

Patient's Name _____ Social Security # _____ - _____ - _____

Address _____ City _____ State _____ Zip _____

Date of birth _____ Sex _____ Cell Phone (_____) _____ Home Phone (_____) _____

Emergency Contact _____ Phone (_____) _____ Relationship _____

We use an online portal "***Follow My Health***," a website where you are able to access your medical records, request appointments, send messages and request medication refills. To utilize this feature, please circle yes or no below.

Email _____ Yes / No

Family physician _____ Referring physician _____

How did you hear about our practice? _____

Insurance Information

Primary Insurance Company _____

Subscriber _____ Subscriber Date of Birth _____

Relationship to patient _____ ID# _____ Group# _____

Secondary Insurance Company _____

Subscriber _____ Subscriber Date of Birth _____

Relationship to patient _____ ID# _____ Group# _____

HIPPA & Insurance Authorization

I hereby authorize this office to furnish information to insurance carriers. I understand that I am legally responsible for any amount of money due that is not covered by my insurance. I have read and understand the above. _____ I am aware that this office may contact me to confirm appointments and discuss my healthcare treatment.
I authorize the release of my (PHI) Private Healthcare Information to

the following person: _____ Relationship_____

Signature _____ Date _____