WELCOME TO ALLERGY ASTHMA ASSOCIATES PC

Please print clearly and complete ALL Registration Information

Patient Information

Patient first name_____ Patient last name _____Middle_____
S.S #____ ____ ____ D.O.B ____ ____ ____ Gender _____
Local home address.
Street_____ Apt # _____ City_____ State _____ Zip_____
Home Phone ____ ____ ____ Work Phone ____ ____ ____
Cell Phone ____ ____ ____ May we call you on your cell yes No Preferred Phone ____ ____ ____
Mailing address.
Street _____City _____State _____ Zip _____

For government meaningful use requirement we ask the following

Race	Ethnicity	Preferred language
_____	_____	_____
__ Refuse to report	__ Refuse to report	__ Other

Patient Pharmacy name & Phone # ____ ____ ____ Primary Care physician _____
Referring Physician _____

Patient Billing
Send statement to _____ Relationship to the patient _____
Address _____ City _____ State_____ Zip_____

Patient primary Insurance

Ins. Name _____ Member ID# _____ Group #_____
Start date _____ _____ ____ Copay $ _____
Insured name: _____Insured S.S._____ Relationship to patient_____
Insured D.O.B ____ ____ ____ Insured Address _____City _____ State____ Zip_____
Insured Employer _____

Patient Secondary Insurance

Ins. Name _____ Member ID# _____ Group #_____
Start date _____ _____ ____ Copay $ _____
Insured name:_____Insured S.S. _____ Relationship to patient_____
Insured D.O.B ____ ____ ____ Insured Address _____City _____ State____ Zip_____
Insured Employer _____

Patient Signature _____ Date_____

Guardian Signature/ Patient is Minor _____ Date _____

Guardian Full Name _____ Relation _____

Minor's Father Name _____ Minor's Mother Name _____