Rand E. Dankner, M.D.
Jacqueline L. Reiss, M. D.

Patient Information

Please Print When Filling Out This Form Date : _____/_____/_____(if new patient, date of first appointment)

Patient's Name: ____ Age ___________
(Last) (Middle) (First)
Address: ____
Street City State Zip
Phone: Home ( ) _____________ Work ( ) ___________Cell ( )_______________
E-Mail Address: ___________________________ Social Security # ___________________
Your E-mail Address is protected by and only used by Allergy Associates, Inc operations
Date of Birth _____________ Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐Married ☐ Divorced
Have you or other family members received medical care by our practice? Who: ___________ When: ___________

Physician Information

Primary Care Physician (PCP) ____________________________Phone: ( ) ___________
Address: ____
Specialist: ____Phone: ( ) ___________
Address: ____
I give my permission to send a written report(s) to the above Doctors: ☐ Yes ☐ No

Referral Source

How did you hear about Allergy Associates, Dr. Dankner or Dr. Reiss?

☐ Referred by a physician: Physicians name: ______________________________
☐ Referred by family member or friend who
has received care from our practice: ______________________________
☐ Other: ____

Employment Information

Complete this area for the patient Or parent/guardian of a minor

Name: _______________Relationship: ________
Date of Birth: _________ SSN # ______________
Employer: ______________________________
Phone #: _______________
Employer Address: _______________________
City: _______________ State _____ Zip ______

Complete this area for the spouse Or the 2nd parent/guardian of a minor

Name: _______________Relationship: ________
Date of Birth: _________ SSN # ______________
Employer: ______________________________
Phone #: _______________
Employer Address: _______________________
City: _______________ State _____ Zip ______

Insurance

PRIMARY INSURANCE
Name of Insurance plan ______________________________
Name of person who carries insurance ___________________
Insurance Identification Number ______________________
Group Number ____________________________________
Date insurance began _________________ Copay $ ________

SECONDARY INSURANCE
Name of Insurance plan ______________________________
Name of person who carries insurance ___________________
Insurance Identification Number ______________________
Group Number ____________________________________
Date insurance began _________________ Copay $ ________

Billing Procedure

Billing Procedure
I authorize the release of any medical or other information necessary to process insurance claims for services received from Allergy Associates, Inc. I also request payment of government benefits to myself or to the party who accepts assignment. I understand I am financially responsible for charges not covered by this authorization.
I understand and agree if care at Allergy Associates, Inc requires Primary Care Physician referral; it is my responsibility to see that the referral is current prior to receiving care at Allergy Associates, Inc. If no referral is present in advance, I agree to pay for charges at the time of service.

Signature ____Relationship to Patient_____________

Consent for care of minors: Because my son/daughter is a minor (less than 18 years of age) and primarily supported by parent or guardian, I understand and agree that he/she may be evaluated and/or treated by Allergy Associates, Inc staff if I am not present to give consent. This may include, but not necessarily be limited to, physical exams, skin tests, laboratory tests, allergy injections and the prescription of medications in my absence. This agreement will be in effect until revoked by me in writing.

Signature ____Relationship to Patient_____________