

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 () _____	
Email Address: _____		Social Security #: _____		
Your email address is protected by and only used by Allergy Associates, Inc operations				
Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow				
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: <input type="checkbox"/> Yes <input type="checkbox"/> No

Referral Source	How did you hear about Allergy Associates, Dr. Dankner, or Dr. Reiss?
	<input type="checkbox"/> Referred by a physician: Physicians name: _____ <input type="checkbox"/> Referred by family member or friend who has received care from our practice: _____ <input type="checkbox"/> Other: _____

Employment Information	<p>Complete this area for the patient OR parent/guardian of a minor</p> <p>Name: _____ Relationship: _____</p> <p>Date of Birth: _____ SSN#: _____</p> <p>Employer: _____</p> <p>Phone #: _____</p> <p>Employer Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>	<p>Complete this area for the spouse OR the 2nd parent/guardian of a minor</p> <p>Name: _____ Relationship: _____</p> <p>Date of Birth: _____ SSN#: _____</p> <p>Employer: _____</p> <p>Phone #: _____</p> <p>Employer Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
------------------------	--	---

Insurance	PRIMARY INSURANCE Name of Insurance plan: _____ Name of the person who carries insurance: _____ Insurance Identification Number: _____ Group Number: _____ Date Insurance began: _____ Copay \$ _____	SECONDARY INSURANCE Name of Insurance plan: _____ Name of the 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 _____