Northwest Asthma & Allergy Center, P.S.

GENERAL PATIENT INFORMATION

(This information is necessary for our files and will be considered confidential)

DATE ____________________

PATIENTS LAST NAME ____ FIRST NAME ____ MIDDLE ____ HOME PHONE ( )

CURRENT STREET ADDRESS ____ CITY ____ STATE ____ ZIP ____

DATE OF BIRTH ____ AGE ____ SEX: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

SOCIAL SECURITY NUMBER OF PATIENT ____ EMAIL ____ CELL PHONE ____

EMPLOYER ____

OCCUPATION ____ WORK PHONE ( )

SPOUSE'S NAME ____ WORK PHONE ( )

OTHER FAMILY MEMBERS SEEN IN THIS OFFICE - NAME ____ WHICH DOCTOR HAVE THEY SEEN? ____ RELATIONSHIP ____

NAME OF PERSON TO NOTIFY (OUTSIDE THE HOME) IN CASE OF EMERGENCY ____ PHONE # ____ RELATIONSHIP ____

WERE YOU REFERRED TO THIS OFFICE BY A HEALTH CARE PROVIDER? ____ IF SO, NAME ____ ADDRESS ____ PHONE ____

DO YOU WANT RECORDS SENT TO YOUR PRIMARY CARE PHYSICIAN? ____ IF SO, NAME ____ ADDRESS ____ PHONE ____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY ____ EMPLOYER OF SUBSCRIBER ____

ADDRESS ____ BIRTH DATE OF SUBSCRIBER ____

SUBSCRIBERS NAME (Name of person with Insurance) ____ SUBSCRIBERS SOCIAL SECURITY NUMBER/ID NUMBER ____ GROUP OR LOCAL NUMBER ____

SUBSCRIBERS RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ OTHER ____

SECONDARY INSURANCE COMPANY ____ EMPLOYER OF SUBSCRIBER ____

ADDRESS ____ BIRTH DATE OF SUBSCRIBER ____

SUBSCRIBERS NAME (Name of person with Insurance) ____ SUBSCRIBERS SOCIAL SECURITY NUMBER/ID NUMBER ____ GROUP OR LOCAL NUMBER ____

SUBSCRIBERS RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ OTHER ____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance company to pay directly to the Doctor the amount(s) due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the doctor for payment of the entire bill.

Patient's or Guarantor's Signature ____________________ Relationship to patient ____________

Print Name of Signature Above ____________________