Today's Date _____ Primary Care Physician _____ Referring Physician _____

(Information below will be the ONLY communication we will use to contact you for a COURTESY appointment reminder. Please understand it is your responsibility to know when your appointment is.

PREFERRED CONTACT CELL#: _____ (If you do not have a cell that receives texts, please let the office know.

COMMUNICATION EMAIL: _____

PATIENT FIRST NAME _____ **MIDDLE** _____ **LAST NAME** _____

Date of Birth _____ **Marital Status**: S M D W **Sex:** M F **Full-Time Student:** Y N **Part-Time Student:** Y N

Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

Patient's Name of Employer/Business _____ *Patient Occupation* _____ *Work Phone#* _____

Patient's Employer Address _____ *City* _____ *State* _____ *Zip Code* _____

Emergency Contact: Name _____ Relationship _____ Phone# _____

*****Please fill out ALL insurance information below in addition to providing a copy of your insurance ID card to be scanned into our EMR system. Thank you.**

INITIAL HERE IF PATIENT HAS NO SECONDARY INSURANCE: _____

PRIMARY INSURANCE *(ID card must be presented at each visit)*

Insurance Co _____ **Effective Date** _____

INS ID# _____ Grp# _____ Referral Required? Y N

Policy Holder Name _____

Policy Holder Address: _____

DOB _____ **Relationship to Patient** _____

Policy Holder Employer _____ **Occupation** _____

COMPLETE BELOW FOR SECONDARY INSURANCE INFORMATION:

Insurance Co _____ **Effective Date** _____

INS ID# _____ Grp# _____ Referral Required? Y N

Policy Holder Name _____

Policy Holder Address: _____

DOB _____ **Relationship to Patient** _____

Policy Holder Employer _____ **Occupation** _____

PARENT/LEGAL GUARDIAN INFORMATION *(***Please fill out all information if patient is a minor)*

Name _____ DOB _____ Sex M F Live with Child? ( ) YES ( ) NO

Address (if different from above) _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ E-Mail Address _____

Employer _____ Employer Phone# _____ Occupation _____

Name _____ DOB _____ Sex M F Live with Child? ( ) YES ( ) NO

Address (if different from above) _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ E-Mail Address _____

Employer _____ Employer Phone# _____ Occupation _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES & PATIENT BILL OF RIGHTS

The Allergy & Asthma Diagnostic Office has posted their "Notice of Privacy Practices" and Patient's Bill of Rights & Responsibilities in the patient waiting room and on their website at www.allergyaway.com. I understand that upon request, I am entitled to receive a paper copy at any time. I understand the Allergy & Asthma Diagnostic Office reserves the right to change the privacy practices policy to remain in compliant with HIPAA Regulations.

REQUEST FOR SERVICE AUTHORIZATION

I hereby authorize providers of the Allergy and Asthma Diagnostic Office to furnish medical services to me and consent to the performance of any diagnostic studies and medical treatment as discussed and mutually agreed to. (or, if I am executing this agreement as a parent or legal guardian of a child)
I hereby authorize the release of any medical information necessary to process any claims to my insurance carrier regarding this and subsequent visits to this office.

I certify that the information given by me in applying for payment by my insurance company is correct and that I will notify AADO with any changes in medical insurance. I authorize and request that payment of benefits by my insurance carrier be made directly to the AADO for services furnished to me or my dependent. I further understand that I may be responsible for all charges not covered by this assignment.
PLEASE NOTE: It is necessary that all requested information be completed prior to treatment. This form will need to be completed yearly and when any change in information occurs. Our office will submit to your insurance carrier providing we have all the necessary information, otherwise payment in full may be requested at the time of service. ALL CO-PAYMENTS ARE PAYABLE AT THE TIME OF SERVICE; otherwise a $20.00 billing charge will automatically be added to your account. Thank You.

I have read the above certification, or it has been read to me and I fully understand these statements.

_____ _____ _____ _____

PRINTED Name of Patient/Legal Guardian Date **Signature** of Patient/Legal Guardian Date (REV:4.21)