<u>**Patient Information**</u>

Fax to: 281.647.9198

Please print the following information: Age: ________ Date: ____________________

Patient's Name (Last Name) (First Name) (MI)	Date of Birth:
	Sex:
Home Address	Primary Phone:
City State Zip Code	Secondary Phone:
Employer's Address	Employer Name
City State Zip Code	Phone:
Name of nearest relative (not living with you) ***This person will be notified in case of an emergency***	Phone:
	Relationship to Patient:
Name of Insured (Last Name) (First Name) (MI)	Date of Birth:
Relationship of patient to insured:	SS#:
Insured's Employer Name & Address	
Insured's Employer Home Address (if different from above)	Phone:
Name of referring physician:	
Name of primary care physician:	

All information submitted above is true to the best of my knowledge. I authorize the release of any medical or other information to process claims and I authorize payment of medical benefits to West Houston Allergy & Asthma, P.A.- Dr. Pardeep S. Rihal.
I authorize consultaion and treatment for services rendered.

PLEASE NOTE THAT BENEFITS THAT ARE QUOTED ARE NOT A GUARANTEE OF COVERAGE, WE RECOMMEND THAT THE INSURED CONTACT HIS/HER INSURANCE COMPANY TO DETERMINE BENEFITS AND ELIGIBILITY. THE INSURED IS RESPONSIBLE FOR ALL CHARGES (i.e. deductibles, pre-existing conditions, etc.) THE AMOUNT COLLECTED MAY NOT BE THE FINAL CHARGES AS THESE WILL BE DETERMINED AFTER YOUR CLAIMS ARE PROCESSED BY THE INSURANCE COMPANY.

Signature of Patient/Responsible party:___________________________________ Date:_____________