# PATIENT INFORMATION

Patient's last name_____First_____MI_____

Address_____City_____State_____Zip_____

Home phone_____Work_____Mobile_____

Date of birth_____Sex: Male____Female____Marital Status_____

Social security number_____Employer_____

Emergency contact_____Phone_____

Primary Physician_____ PCP Phone _____

Referring Physician _____ Ref Dr. Phone _____

**Responsible Party if Patient is a Minor:**

Name_____Relationship_____

Address_____City_____State_____Zip_____

Home phone_____Work_____Mobile_____

Social security number_____Date of birth_____

**Insurance Information**

**Primary**_____ID#_____Group#_____

Policyholder_____Date of birth_____

Social security number_____Relationship to patient_____

Effective dates_____

**Secondary**_____ID#_____Group#_____

Policyholder_____Date of birth_____

Social security number_____Relationship to patient_____

Effective dates_____

***Authorization: I hereby authorize the physicians and representatives of Allergy and Asthma Specialists of Greater Washington to furnish medical treatment and provide information concerning my visits to my insurance carrier. I direct the insurer to pay any and all funds to Allergy and Asthma Specialists of Greater Washington directly. I am aware that I am personally responsible for all charges incurred during treatment whether covered by insurance or not. Co-payments and deductibles are due at the time of service. Patient or guarantor is responsible for all collection fees and costs for the collection of delinquent accounts. HMO patients are responsible for securing and managing referral forms for their services. Your signature below signifies your consent for treatment as well as your understanding of this payment policy.***

Signature of patient or responsible party_____ Date_____

How did you hear about our practice?_____

Please verify yearly by providing your initials and date on one of the lines below.

_____ _____ _____ _____