PATIENT INFORMATION

PATIENT NAME:_____
LAST FIRST MIDDLE

ADDRESS:_____

CITY:_____ STATE:_____ _____ ZIP CODE: _____

HOME PHONE #: (_____)_____ WORK PHONE #: (_____)_____ EMAIL: _____

DATE OF BIRTH:_____/_____/_____ SOCIAL SECURITY NUMBER: _____

SEX: (CIRCLE ONE) F M MARITAL STATUS: (CIRCLE ONE) S M D W OTHER: _____

PATIENT RELATIONSHIP TO RESPONSIBLE PARTY: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

PRIMARY CARE PHYSICIAN:_____ REFERRED BY:_____

PATIENT'S EMPLOYER INFORMATION:

COMPANY: _____ PHONE: _____

RESPONSIBLE PARTY (OR INSURED) INFORMATION

RESPONSIBLE PARTY NAME:_____
LAST FIRST MIDDLE

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE: _____

HOME PHONE #: (_____)_____ WORK PHONE #: (_____)_____ EMAIL: _____

DATE OF BIRTH:_____/_____/_____ SOCIAL SECURITY NUMBER: _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION:

COMPANY: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

SUBSCRIBER NAME:_____
LAST FIRST MIDDLE

ADDRESS:_____
CITY STATE ZIP

CONTRACT (ID) #: _____ CUSTOMER SERVICE PHONE: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: _____ INSURED'S DATE OF BIRTH: _____

SECONDARY INSURANCE COMPANY: _____

SUBSCRIBER NAME:_____
LAST FIRST MIDDLE

ADDRESS:_____
CITY STATE ZIP

CONTRACT (ID) #: _____ CUSTOMER SERVICE PHONE: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: _____ INSURED'S DATE OF BIRTH: _____

The undersigned agrees, whether he signs as agent or as a patient, that in consideration of services to be rendered (e.g. skin testing, office visit etc.) by AACSWWA, to the patient named above, he hereby obligates himself, assumes financial responsibility, and agrees to pay upon request to provider all charges for such services incurred by said patient. Should the account be referred to an attorney/collection agency for collection, the undersigned shall pay all responsible attorney fees and collection expenses. The undersigned understands that all bills are payable upon presentation and that she/he, not the insurance company, is responsible for the payment of the services. This office will file and collect from Insurance when insurance benefits are present. I hereby authorize Allergy & Asthma Center of SW Washington to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered on above patient.

_____ _____
SIGNATURE DATE