PATIENT INFORMATION

PATIENT NAME: _____
LAST FIRST

ADDRESS:_____

CITY/STATE/ZIP:_____ SEX: (CIRCLE ONE) F M

PRIMARY PHONE #: (_____)_____ (CIRCLE ONE) HOME CELL WORK

SECONDARY PHONE #: (_____)_____(CIRCLE ONE) HOME CELL WORK

DATE OF BIRTH:_____/_____/_____ SSN: _____

MARITAL STATUS: (CIRCLE ONE) S M D W REFERRED BY/PHYSICIAN:_____

EMAIL: _____ PCP OFFICE & PHONE:_____

PARENT/RESPONSIBLE PARTY INFORMATION

PARENT / RESPONSIBLE PARTY NAME:_____
LAST FIRST

RELATIONSHIP TO PATIENT: (CIRCLE ONE) SELF SPOUSE PARENT OTHER

OTHER PARENTS NAME:_____
LAST FIRST

ADDRESS (IF DIFFERENT FROM ABOVE)_____

CITY/STATE/ZIP:_____ DATE OF BIRTH:_____/_____/_____

OKAY TO LEAVE MESSAGE ON PHONE: (CIRCLE ONE) YES NO SSN: _____

PRIMARY PHONE #: (_____)_____ (CIRCLE ONE) HOME CELL WORK

SECONDARY PHONE #: (_____)_____(CIRCLE ONE) HOME CELL WORK

RESPONSIBLE PARTY'S EMPLOYER INFORMATION:

COMPANY: _____ TITLE: _____

INSURANCE INFORMATION

SUBSCRIBER NAME:_____
LAST FIRST MIDDLE

INSURED'S DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER

PRIMARY INSURANCE COMPANY: _____

MEMBER/SUBSCRIBER/ID #: _____ GROUP NUMBER: _____

EMPLOYER: _____ SECONDARY INS: YES NO

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