

ALLERGY & ASTHMA INSTITUTE OF THE VALLEY

PATIENT INFORMATION

Account # _____

(PLEASE PRINT)

Today's Date: _____

Patient's Name: _____ Age: _____ Sex: _____ DOB: _____
(LAST) (FIRST)

*If patient is a minor child please list: Mother's name _____
Father's name _____

Patient Social Security # _____ - _____ - _____

Home Address: _____

City: _____ State _____ ZIP: _____ Telephone: () _____
Cell phone: () _____
E-Mail _____

Do you have Medical Insurance? yes no If yes, please list all information below.

Name of Insured: _____

Name of Insurance Co.: _____

Group # _____ Subscriber # _____

Insured Employed by: _____

Occupation: _____ Bus. Phone () _____ SS# _____ - _____ - _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

Referred by Doctor: _____ Telephone: () _____
Address: _____ City: _____ ZIP: _____

Referred by Friend: _____

Referred by Ins. Co _____ Internet: _____ Phone book: _____ Other: _____

Who to contact in case of emergency: _____

Relationship: _____ Telephone: () _____

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN FOR MEDICAL SERVICES RENDERED. I AUTHORIZED THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE BENEFITS.

I understand and agree to the above statements. Patient's Signature: _____

24 hour notice is required to cancel all scheduled appointments.
This office reserves the right to charge a cancellation fee if this requirement not met.