Allergy and Asthma Center of the Tri-State, Inc.

Mark Michael, M.D.

Patient Information

Name (First) _____ (MI) _____ (Last) _____

Address _____City, State_____Zip_____

Home #: _____ Work #: _____ Cell #: _____

Medical information may be released to: _____ Message may be left on voice mail: Y or N

SS#: _____ **D.O.B.** _____ **Sex:** ☐ M ☐ F **Marital Status**: ☐ S ☐ M ☐ W ☐ D ☐ Other

Employer: _____ Occupation:_____

Is the patient allergic to any medications: ( ) No ( ) Yes (if yes please list): _____

Primary Physician: _____ Phone#: _____

Referring Physician: _____ Phone#: _____

Do you have any relatives treated in our office? N ( ) Y ( ) Name: _____ Relation: _____

If patient is minor: Student ( ) full time ( ) part time Father's name: _____Mother's name: _____

Responsible Party Information

(If different from Patient)

Name (First) _____ (MI) _____ (Last) _____

Address _____City, State_____Zip_____

Home #: _____ Work #: _____ Cell #: _____

SS#: _____ **D.O.B.** _____ **Sex:** ☐ M ☐ F **Marital Status**: ☐ S ☐ M ☐ W ☐ D ☐ Other

Insurance Information

Primary Insurance(subscriber's information)

Insurance Name : _____

Group #: _____

ID#:_____

Insured Name: _____

Insured Address:_____

City, State: _____ Zip: _____

Employer's Name :_____

Occupation: _____

Employer's Phone :_____

Insured SS #:_____DOB:_____

Relation to patient: ☐ self ☐ spouse ☐ parent ☐ other

Secondary Insurance(subscriber's information)

Insurance Name :_____

Group #:_____

ID#:_____

Insured Name:_____

Insured Address:_____

City, State: _____ Zip: _____

Employer's Name:_____

Occupation: _____

Employer's Phone:_____

Insured SS #:_____DOB:_____

Relation to patient: ☐ self ☐ spouse ☐ parent ☐ other

Authorization

I authorize Allergy & Asthma Center of the Tri-State, Inc. to: (1) Treat the above named patient. (2) The use of this form on all my insurance submissions. (3) The release of information to all my insurance companies. (4) Get payments directly from insurance companies. **I understand that I am responsible for payments for services rendered and not paid for by insurance companies.**

I have received the Notice of Privacy Practices for Protected Health Information.

If the above named patient is younger than 18 years I authorize treatment without the presence of a parent. **Y( ) N( )**

Signature:_____ *Date*:_____

Printed Name: _____ Relation to Patient: ( ) Self ( ) Other: _____

Chart # : _____ Patient's code:_____ Type: _____ Entered by:_____ Date: _____