

# Welcome To Our Office 2012

## PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Nickname: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SS#: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Birthdate \_\_\_\_\_ Age: \_\_\_\_\_ Marital: single married widowed divorced

E-mail address \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Please choose how you would like to be reminded of your appointment: phone message or email

Do you grant permission for us to leave messages on your answering machine or cell? Yes No

Spouse \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance \_\_\_\_\_ Work Phone: \_\_\_\_\_

If carried on Spouse's Insurance please circle if Primary or Secondary Insurance

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

Emergency Contact (Someone outside of your home) \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**This Box Must Be Filled Out By All Patients That Are On Their Parent's Insurance  
And All Minor Children**

Is this Primary or Secondary Insurance

Father's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City/St \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance \_\_\_\_\_ Work Phone \_\_\_\_\_

Plan/Group # \_\_\_\_\_ Marital Status \_\_\_\_\_

Email address \_\_\_\_\_

Is this Primary or Secondary Insurance

Mother's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City/St \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance \_\_\_\_\_ Work Phone \_\_\_\_\_

Plan/Group # \_\_\_\_\_ Marital Status \_\_\_\_\_

Email address \_\_\_\_\_

I hereby authorize Paragon Health DBA Advanced Allergy & Asthma Care to examine and treat me or my child and to perform such diagnostic tests as may be necessary for the duration of this illness. I hereby authorize the release of any medical information necessary to process my insurance claims and for any benefits payable under my policy be paid directly to Advanced Allergy & Asthma Care. I understand that I am ultimately responsible for all payments not paid by my Insurance. I understand that this information may include information related to the diagnosis and/or treatment of alcohol/substance abuse, psychological/mental disorders and or HIV serostatus. I understand that I am responsible for payment of any charges incurred.

Signature of PATIENT (or Guardian) \_\_\_\_\_ Date \_\_\_\_\_