

Welcome To Our Office 2010

PATIENT INFORMATION

Male _____ Female _____ Appointment Date _____

Last Name: _____ Street Address: _____
First Name: _____ MI: _____ City: _____ State: _____ Zip: _____
SS# _____ Home Phone _____ Cell/Pager _____
Birthdate _____ Age: _____ Marital: single married widowed divorced
E-mail address _____
Employer & Address: _____ Occupation: _____
Insurance & Address: _____ Work Phone: _____

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

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

Spouse _____ Birthdate _____ SS# _____
Employer & Address: _____ Occupation: _____
Insurance & Address _____ Work Phone: _____

Primary Care Physician _____ Referring Physician _____
Emergency Contact (Someone outside of your Home) _____
Phone _____ Relationship _____

FILL OUT THIS BOX IF PATIENT IS UNDER 18 OR IF COVERED UNDER PARENT INSURANCE

Father's Name _____ Birthdate _____ SS# _____
Address _____ City/St _____ Zip _____ Phone _____
Employer & Address _____ Occupation _____
Insurance Company & Address _____ Work Phone _____
Plan/Group # _____ Marital Status _____
Email address _____

Mother's Name _____ Birthdate _____ SS# _____
Address _____ City/St _____ Zip _____ Phone _____
Employer & Address _____ Occupation _____
Insurance Company & Address _____ 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 Medicare and/or 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 Medicare/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** _____