



**PATIENT INFORMATION SHEET**

**PLEASE PRINT DATE:** \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ DOB \_\_\_\_\_ M / F  
ADDRESS \_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
**BEST NUMBER TO REACH YOU DURING THE DAY (\_\_\_\_) \_\_\_\_\_**  
WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_  
MARITAL STATUS \_\_\_\_\_ ETHNIC ORIGIN \_\_\_\_\_  
2 EMERGENCY CONTACT PHONE#s: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_  
PATIENT MEDICATION ALLERGIES OR NONE \_\_\_\_\_  
REASON FOR VISIT \_\_\_\_\_  
PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_  
REFERRED BY \_\_\_\_\_ PHONE \_\_\_\_\_

**INSURANCE INFORMATION:**

INSURANCE CARRIER \_\_\_\_\_  
POLICY HOLDER \_\_\_\_\_ DOB \_\_\_\_\_ GROUP ID \_\_\_\_\_  
MEMBER NUMBER \_\_\_\_\_ EMPLOYER NAME \_\_\_\_\_  
SECONDARY INSURANCE \_\_\_\_\_ GROUP ID \_\_\_\_\_  
POLICY HOLDER \_\_\_\_\_ DOB \_\_\_\_\_ MEMBER NUMBER \_\_\_\_\_  
EMPLOYER \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT** \_\_\_\_\_

SS# \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_  
ADDRESS (if different from patient) \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF MEDICAL INFORMATION**

I \_\_\_\_\_, HEREBY AUTHORIZE THE RELEASE OF MY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY PHYSICIAN TO SUBMIT CLAIMS FOR BENEFITS FOR SERVICES RENDERED WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND/OR DEPENDENTS, AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM. I \_\_\_\_\_, HEREBY AUTHORIZE MY INSURANCE COMPANY(IES) TO PAY AND HEREBY ASSIGN DIRECTLY TO ALLERGY, ASTHMA AND IMMUNOLOGY ASSOCIATES OF SOUTH TEXAS ALL BENEFITS PAYABLE FOR SERVICES PERFORMED.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. AS A COURTESY, ALLERGY, ASTHMA AND IMMUNOLOGY ASSOCIATES WILL FILE MY INSURANCE CLAIM FOR ME. CO-PAY AND DEDUCTIBLES ARE DUE AT TIME OF VISIT. IF MY INSURANCE COMPANY DOES NOT PAY WITHIN 90 DAYS, I WILL BE BILLED FOR SERVICES RENDERED. IF AN INSURANCE CHECK IS LATER RECEIVED FROM MY INSURER, ANY OVERPAYMENT WILL BE REFUNDED TO ME.

Signature / Guardian \_\_\_\_\_

DATE \_\_\_\_\_

**Main Office:**  
Medical Center  
2424 Babcock Rd. Ste 301  
San Antonio, TX 78229

**Southside:**  
SW Medical Bldg.  
7500 Barlite Blvd. Ste 106  
San Antonio, TX 78224

T: 210-616-0882  
F: 210-692-7833  
**allergyusa.com**