ALLERGYSA.COM
Allergy, Asthma & Immunology
ASSOCIATES OF SOUTH TEXAS

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 SUBMIITTED 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 DEDUCTIBES 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 _____

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