Institute for Asthma and Allergy

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ESTABLISHED PATIENT REGISTRATION

Due to recent **HIPPA** requirements, all of our patients are being asked to complete this form.

PLEASE PRINT CLEARLY

Patient's Name: ______________________ Date of Birth: ___/___/______

Address: ______________________, ____________, __________ ________
CITY STATE ZIP CODE

Cell # (_____) ______________ (best used for appointment confirmations!)
Home # (_____) ______________
*Work # (_____) ______________ (*Patient or Primary Care Giver)
*EMAIL: ______________________ (*Patient or Primary Care Giver)

Name of Primary Care Physician: ______________ ______________
FIRST NAME LAST NAME

Name of Insurance Company: ______________ HMO PPO OPEN ACCESS
Insurance PO Box or Street address for claims: ______________________

______________, __________ ________
CITY STATE ZIP CODE

Insurance ID #, Policy Number # or Subscriber #: ______________ - ____
Member suffix

Insurance Group #: ______________ Effective Date of Policy: _____-_____-______
Is the above insurance information NEW? ___ YES ___ NO
Name of Policy Holder: ______________________
Name of Policy Holder's Address: ______________________

______________, __________ ________
CITY STATE ZIP CODE

Relationship of Policy Holder to the patient (Check One):

____ Mother ____ Father ____ Self
____ Husband ____ Wife ____ Other: __________

Policy Holder's Employer: ______________________
Policy Holder's Date of Birth: ____/____/______

PLEASE PRESENT YOUR CURRENT INSURANCE CARD TO THE FRONT DESK.
By signing below, I request payment of authorized insurance company benefits be made on my behalf to the Institute for Asthma & Allergy, P.C. for any services furnished to me by a physician at this practice.

______________________ ______________________
NAME OF PERSON COMPLETING THIS FORM SIGNATURE OF PERSON COMPLETING THIS FORM

DATE: ______________