Appointment :

Patient's Last name : ____________ First name : ____________ MI : ____

Address : ________________________________

City : ____________ State code : ____ Zipcode : ____________

Referral Dr : ____________ Sex (M/F) : ____ Marital Status : ____ S M D W

Birthday : _____/_____/_____ Social sec : _____/_____/_____

Home Phone : (_____) ____________ Work Phone : (_____) ____________

Emergency : ____________ Emer Phone : (_____) ____________

Email : ____________ Cell Phone : (_____) ____________

== Primary Insurance Coverage ========

Company : ____________

Insured name : ____________

Relationship : ________ DOB: ________

Co-pay amount : ____________

Policy number : ____________

Group number : ____________

Employer : ____________

== Secondary Insurance Coverage ========

Company : ____________

Insured name : ____________

Relationship : ________ DOB: ________

Co-pay amount : ____________

Policy number : ____________

Group number : ____________

Employer : ____________

== Guarantor Information ===

Guarantor : ________________________________

Address : ________________________________

City : ____________ State code : ____ Zipcode : ____________

Telephone # : (_____) ____________ Miscellaneous : ____________

Patient's Authorization

I authorize ASTHMA, ALLERGY + SINUS CENTER to apply for benefits on my behalf for services rendered by ASTHMA, ALLERGY + SINUS CENTER. I request payment from my insurance company be made directly to ASTHMA, ALLERGY + SINUS CENTER. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

________________________________ ____________

Signature of Subscriber or Beneficiary Date