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New Patient Information

TODAY'S DATE: _____

PATIENT'S NAME _____ DOB _____ MALE / FEMALE

ADDRESS _____ HOME PHONE (_____) _____

CITY _____ STATE _____ ZIP _____

BEST NUMBER TO REACH YOU DURING THE DAY (_____) _____

WORK PHONE (_____) _____ CELL PHONE (_____) _____

EMAIL ADDRESS _____

MARITAL STATUS _____ LANGUAGE: English Other: _____

ETHNICITY/ RACE: American Indian or Alaskan Native Asian Black or African American

Hispanic or Latino Native Hawaiian or Pacific Islander White Other: _____

EMERGENCY CONTACT PHONE NUMBERS #1 (_____) _____ #2 (_____) _____

RELATIONSHIP TO PATIENT #1 _____ #2 _____

PATIENT MEDICATION ALLERGIES OR NONE _____

REASON FOR VISIT _____

PRIMARY CARE PHYSICIAN _____ PHONE (_____) _____

REFERRED BY _____ PHONE (_____) _____

PREFERRED PHARMACY _____ 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 Apex Allergy and Asthma, PLLC or its assigns all benefits payable for services performed.

I understand I am financially responsible for all charges incurred. As a courtesy, Apex Allergy and Asthma, PLLC or its assigns 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 _____