DALLAS ASTHMA & ALLERGY CENTER

(TO BE FILLED IN COMPLETELY – PLEASE PRINT)

I. PATIENT INFORMATION: TODAY'S DATE____________

PATIENT'S NAME______________________________ DATE OF BIRTH____________

ADDRESS______________________________ HOME TEL #____________

Street Apt #

______________________________ MOBILE #____________

City State Zip

EMPLOYER______________________________ WORK TEL #____________

SOCIAL SECURITY #____________________ DRIVER'S LICENSE #____________

SPOUSE'S NAME______________________________ WORK TEL # ____________

FAMILY PHYSICIAN______________________________

Name Address

REFERRED BY______________________________

Name

II. RESPONSIBLE PARTY INFORMATION: (Please complete if patient is a minor.)

NAME______________________________ SPOUSE'S NAME____________

ADDRESS______________________________ HOME TEL #____________

Street Apt #

______________________________ MOBILE #____________

City State Zip

EMPLOYER______________________________ WORK TEL #____________

SOCIAL SECURITY #____________________ DRIVER'S LICENSE #____________

III. INSURANCE INFORMATION: (Disclose whether insurance is through your employer or spouse's employer)

NAME OF INSURED____________________ RELATIONSHIP TO PATIENT____________

EMPLOYER______________________________ WORK TEL #____________

NAME OF INSURED'S HEALTH INSURANCE CO.______________________________

I consent to examination, diagnosis and treatment as prescribed by the attending physician. I authorize the use or disclosure of my medical records or other personal health information as needed for purposes of treatment, payment (if requested by the insurance company to process claims) or healthcare operations. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I authorize payment of medical benefits to the attending physician for services received at this office. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

______________________________ DATE____________

Patient/Parent Signature

Please See Reverse Side