PATIENT INFORMATION

Today's Date_____

Thank you for choosing our office! In order to serve you properly, we need the following information. PLEASE PRINT NEATLY. All information will be kept confidential.

Patient Name _____ **Date of Birth**_____ **M____ F____**

Responsible Party (if different than patient)_____

Relationship to Patient _____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip Code _____

Billing Address (if different from above)_____

City_____ State_____ Zip Code_____

Home Phone_____ Is it okay to leave a detailed message? Yes No

Cell Phone_____ Is it okay to leave a detailed message? Yes No

Email Address_____

Is it okay to send confidential health information via e-mail? Yes No

Employer _____ Work Phone _____

Marital status: (circle one) Minor S M W D Patient's Social Security No. _____

Emergency Contact Person _____ Phone No. _____

Relationship to Patient (for Emergency Contact Person) _____

Primary Care Physician _____ Phone No. _____

Preferred Pharmacy _____ Phone No. _____

Patient's Race: _____ Patient's Ethnicity: (circle one) Hispanic or Non-Hispanic

Language of Choice: _____

ANY KNOWN DRUG ALLERGIES: _____

_____

_____

If the patient is under 18 years of age, please complete the following.

Father's Name _____ Lives with child? Yes No
Employer _____ Work Phone No. _____
Mother's Name _____ Lives with child? Yes No
Employer _____ Work Phone No. _____

INSURANCE INFORMATION

Insurance Co. _____ Group No. _____ ID No. _____
(Fill out the following information if the patient is not the card-holder)
Card-holder _____ Relationship _____
Birth Date _____ Social Security No. _____ (may be necessary to file insurance)

If you have additional insurance please complete the following:
Insurance Co. _____ Group No. _____ ID No. _____
(Fill out the following information if the patient is not the card-holder)
Card-holder _____ Relationship _____
Birth Date _____ Social Security No. _____ (may be necessary to file insurance)

LIMITS OF CONFIDENTIALITY
By signing below, you are authorizing treatment and the release of medical information necessary to process your insurance claim. You are also authorizing the release of your medical information to referring doctors and/or insurance companies on behalf of Bayside Allergy, PC. If applicable this authorizes us to bill Medicare and release any information needed to determine payment for any specific date of service.

_____PLEASE CHECK HERE IF WE ARE AUTHORIZED TO SHARE MEDICAL INFORMATION WITH ANY IMMEDIATE FAMILY MEMBERS. IF SO, THEN PLEASE LIST NAMES OF PERSONS THAT ARE AUTHORIZED TO RECEIVE INFORMATION.

NAME_____RELATIONSHIP_____
NAME_____RELATIONSHIP_____
NAME_____RELATIONSHIP_____

FINANCIAL POLICIES
1. It is our office policy for you to pay your co-payment at the time of service unless other arrangements have been made. It is your responsibility to know how much your co-pay is. Payment methods available are Cash, Check, MasterCard, Visa, or Discover.
2. We will bill all primary insurances for you, however, you will be responsible for all co- pays, deductibles, and any balance that your insurance does not cover.
3. It is your responsibility to make sure that you have any necessary referrals or authorizations that are required for your insurance from your primary care physician prior to being seen in our office. If you are not sure if a referral or authorization is needed please check with your insurance before your appointment.
4. Please be sure that you have your current insurance card and identification with you at your visit. If we are not provided with a copy of these your insurance may not be billed until we have them.
5. It is your responsibility to know your insurance coverage prior to treatment (i.e.: allergy testing, office visits, allergy injections, allergy serum) as some insurance policies do not have allergy coverage.
6. Regardless of your insurance status, you are ultimately responsible for the balance of your account for all services rendered.

I have read and understand the above statements and have been offered the Notice of Practice Practice in regards to my protected health information at Bayside Allergy, PC.

Patient/Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____