



447 Munson Ave  
Traverse City, MI 49686  
Office: (231) 929-9090 Fax: (231) 929-9092  
[www.baysideallergy.net](http://www.baysideallergy.net)

### PATIENT INFORMATION

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.

**You will be asked to sign electronically that you have read and understand the above statements and have been offered the Notice of Privacy Practices, in regards to your PHI (protected health information), at Bayside Allergy, PC.**