Appointment Date: _____

PATIENT INFORMATION

Please Print

Patient's Legal Name: _____ Preferred Name:_____
(First) (Middle) (Last)

Date of Birth: _____ Male / Female Social Security Number: _____

Cell Phone Number: (_____) _____ Home Phone Number: (_____) _____

Home Address: _____ City: _____ State: _____ Zip:_____

Employer: _____ Position: _____

Work Phone: (_____) _____ Ext: _____ Email Address: _____

Ethnicity: _____ Language: _____ Interpreter Needed: Yes / No

Marital Status: Single / Married / Widowed / Divorced / Life Partner / Other

Spouse Name: _____ DOB: _____ Social Security Number: _____

Phone Number: _____ Employer: _____ Work Phone: _____ Ext. ____

PHYSICIAN REFERRAL INFORMATION

Referring Physician: _____ Primary Care Physician: _____

EMERGENCY/ NEXT OF KIN CONTACT INFORMATION

(Other than Parent/ Legal Guardian/ Spouse)

Name: _____ Relationship: _____

Phone Number: _____

PARENT/ LEGAL GUARDIAN INFORMATION

Parent / Legal Guardian #1
Responsible Party? Yes____ No____
Name: _____ DOB: _____ SSN: _____
Phone Number: _____ Relationship: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Work Phone: _____ Ext. _____

Parent / Legal Guardian #2
Responsible Party? Yes____ No____
Name: _____ DOB: _____ SSN: _____
Phone Number: _____ Relationship: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Work Phone: _____ Ext. _____

Parents are: Married Living Together Separated Divorced If divorced, who is the custodial parent? #1 or #2

PLEASE READ AND SIGN FOR MINOR CHILDREN

If my child/children should require medical care or treatment and I should be unavailable or out of town, I give permission to the providers of Allergy, Asthma and Immunology Associates, P.C. to care for my child/children as these providers deem necessary.

Parent / Legal Guardian Signature: _____Date: _____

MEDICAL INSURANCE

***This entire sheet must be completed in full even though we have copies of your insurance cards. ***

Check here if NO medical insurance: _____

Primary Insurance Company: _____

Subscriber's Name:_____

Relationship to Patient: _____ Subscriber's Date of Birth: _____

Subscriber's ID #: _____ Group #: _____

Medicaid # (if applicable): _____

Do you have a secondary medical insurance? Yes ____ No _____

Secondary Insurance Company:_____

Subscriber's Name: _____

Relationship to Patient: _____ Subscriber's Date of Birth: _____

Subscriber's ID #: _____ Group #: _____

Medicaid # (if applicable): _____

RELEASE OF INFORMATION

I hereby authorize the providers of Allergy, Asthma and Immunology Associates, P.C., to furnish to the insurance company(s) information regarding me or my child's health and treatment. I also hereby assign to the providers all payment for medical services provided to my dependents of me. I understand that to the extent allowable by law, that I am responsible for any amount whether or not covered by the insurance program, Preferred Provider Organization (PPO), or any Health Maintenance Organization (HMO), or any other provider of medical coverage.

Patient (Subscriber) Signature: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have been informed of the Allergy, Asthma, and Immunology Associates, P.C. notice regarding privacy of personal health information. I understand that the notice is posted on the website, www.AllergyNebraska.com and that a copy of the notice is available to me.

Patient / Legal Guardian Signature:_____ Date:_____