



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 / Legal Guardian 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: _____

MEDICARE AUTHORIZATION (IF PATIENT HAS MEDICARE)

I request that payment of authorized MEDICARE payments be made to AAIA, for any services furnished to me by AAIA. I authorize the holder of medical information pertaining to me, to release to MEDICARE and its agents, information needed to determine these benefits or the benefits payable for related services.

Patient or Parent/Legal Guardian Signature: _____ Date: _____