Allergy & Asthma Centers

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Confidential Patient Information

Name: _____ Date of Birth: _____ Age: _____
First MI Last

Address: _____

City: _____ State: _____ Zip: _____

Home Phone:( ) _____ Work Phone:( ) _____ SS# _____

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Either
May we leave a message regarding test results/labs on your answering machine at home? Yes No

Are you: ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Separated Sex: ❑ F ❑ M

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

If you are a student, name of school/college: _____

Emergency Contact: _____ Relationship: _____
Phone #( ) _____

Primary Care Physician: _____
Did a doctor refer you to our office: ❑ Yes ❑ No
If Yes, doctors Name: _____

Address: _____ Phone: _____

Pharmacy Information

Pharmacy Name: _____ City: _____ Phone: _____

Insurance Information

1. Insurance Co. Name: _____ (primary)
   Policy #: _____
   Policy Holder: _____
   Date of Birth: _____
   Employer Name: _____

2. Insurance Co. Name: _____ (secondary)
   Policy #: _____
   Policy Holder: _____
   Date of Birth: _____
   Employer Name: _____

Finacial Assignment and Agreement

1. Please remember that, even with insurance coverage, most patients are responsible for a portion of their medical expenses.
2. We request that your portion/co-pay be paid at the time of the visit.
3. I understand that I am financially responsible for all charges for medical services that are not paid by my insurance company.

Signature (Parent or Guardian, if minor) _____ Date: _____

The Research Division of the Allergy & Asthma Center of Providence participates in Clinical Pharmaceutical Trials. Do we have your permission to contact you with information regarding these trials?

❑ Yes (possibly interested) **❑ Not (definitely not interested)**

For Official Use: SAR PAR NAR A (NLPFT) A (ABNLPFT)