

ALLERGY, ASTHMA & IMMUNOLOGY INSTITUTE

PATIENT DEMOGRAPHIC RECORD

PATIENT: _____ DOB: _____
(Last) (First) (M.I.)

ADDRESS: _____
(Street) (City) (State) (Zip Code)

PHONE: _____

MARITAL STATUS:

Home #: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Work #: _____

GENDER:

Cell #: _____ ☐ Male ☐ Female

Emergency #: _____ SSN: _____

EMPLOYER: _____

OCCUPATION: _____ EMAIL: _____

PRIMARY PHYSICIAN: _____ Phone: _____

Address: _____ Fax: _____

REFERRED BY: _____ Phone: _____

RESPONSIBLE PARTY: _____ SSN: _____ DOB: _____
(IF PATIENT IS A MINOR)

Employer: _____ Work #: _____

PRIMARY INSURANCE: _____ PHONE #: _____

Claims Address: _____

MEMBER ID #: _____ GROUP #: _____

Policy Holder: _____ SSN: _____ DOB: _____

SECONDARY INSURANCE: _____ PHONE #: _____

Claims Address: _____

MEMBER ID #: _____ GROUP #: _____

Policy Holder: _____ SSN: _____ DOB: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS:

I hereby authorize Allergy, Asthma & Immunology Institute, to release any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to Allergy, Asthma & Immunology Institute, for medical care rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance, and I will check my own insurance benefits for allergy care. I acknowledge that I have received and understand the HIPAA Notice of Privacy Practices.

SIGNATURE: _____ DATE: _____