

Allergy & Asthma Center

of Southern Oregon, PC

Edward M. Kerwin, MD Kevin W. Parks, MD
Jennifer K. Milligan, PA-C Jaleh Ostovar, FNP-C

PATIENT INFORMATION

✓Name _____ Age _____ Today's Date _____

Date of Birth _____ Marital Status: Single _____ Married _____

Social Security Number _____ Spouse Name _____

✓Home Phone (____) _____ ✓Work Phone (____) _____ ✓Cell Phone(____) _____

✓E-Mail _____ How would you prefer to be contacted Home Cell Work Email

✓ Mailing Address _____

City _____ State _____ Zip Code _____

✓ Primary Care Physician _____

✓ Referring Physician _____

✓Emergency Contact Name _____ ✓Relationship _____ ✓Emergency Phone (____) _____

Employer _____ Employer Address _____

Responsible Party Information

(Please complete if insurance is through another party)

Name _____ Date of Birth _____

Social Security Number _____

Relationship to patient: Parent _____ Spouse _____ Other _____

Mailing Address _____

City _____ State _____ Zip Code _____

✓Home Phone (____) _____ ✓Work Phone (____) _____ ✓Cell Phone(____) _____

✓E-Mail _____

Employer _____ Employer Address _____

INSURANCE COVERAGE

✓ Primary Insurance Name _____

Name of Policy Holder _____ Date of Birth of Policy Holder _____

Insurance Address _____

City _____ State _____ Zip Code _____

ID Number _____ Group Number _____

Secondary Insurance Name _____

Name of Policy Holder _____ Date of Birth of Policy Holder _____

Insurance Address _____

City _____ State _____ Zip Code _____

ID Number _____ Group Number _____

WE WILL NOT GIVE YOUR E-MAIL ADDRESS TO OUTSIDE PARTIES

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INSURANCE TRACKING SHEET

AUTHORIZATION TO PAY AND RELEASE INFORMATION

I HEREBY ASSIGN ALL MEDICAL AND OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLAN TO ALLERGY & ASTHMA CENTER OF SOUTHERN OREGON, PC. THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT.

✓ SIGNATURE _____ DATE _____

INSURANCE VERIFICATION AT EACH VISIT

✓ Primary/Secondary Insurance	No Change in Address/Phone number	Date Checked	Staff Initial
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
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_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____

✓ ANY CHANGE IN ADDRESS/PHONE NUMBERS (have patient fill out new demographic sheet if ADDRESS changes)

✓ New Address	✓ New Phone Number	Date Checked	Staff Initial
See New Demographic Form _____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____
_____ / _____	_____	_____	_____