Allergy & Asthma Center

of Southern Oregon, PC

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Appointments 1-541-858-1003 Fax (541) 857-4499

Patient Information

Date:

Patient Name: _____ _____ **DOB:** _____ **Age:** _____ **M/F**
First _____ M_____ Last

Mailing Address: _____
Street City State Zip Code

Home Ph: _____ **Cell Ph:** _____ **Work Ph:**_____

Employer:_____ **Emp Ph:** **Emp Address:** _____

E-Mail:_____**How would you prefer to be contacted?** Home ❑ Cell ❑ Work ❑ Email ❑

Marital Status: **Single** ❑ **Married** ❑ **Divorced** ❑ **Widowed** ❑ **Other** ❑_____

Language:_____ **Patient's Ethnicity:** **Hispanic/Latino**_____ **Non-Hisp/Latino**_____ **Other**_____

Patient's Race: Caucasian___ African American___ Asian___ American Indian___ Hisp/Latino ___ Other___ Unknown___

Emergency Contact: _____ **Relation:** **Emergency Phone:**_____

Ok to speak to:_____ **Medications:**_____ **Labs:**_____ **Appts:**_____

Primary Care Doctor:_____ **Referring Doctor:**_____

Insurance Coverage

Primary Insurance: _____ **Address:** _____

Name of Policy Holder:_____ **DOB:** _____
First M Last

ID Number: _____**Group Name:** _____**Relationship to Patient:**_____

Employer: _____ **Emp Ph:** **Emp Address:** _____

___

Secondary Insurance: _____ **Address:** _____

Name of Policy Holder:_____ **DOB:** _____
First _____ M_____ Last

ID Number: _____**Group Name:** _____**Relationship to Patient:**_____

Employer: _____ **Emp Ph:** **Emp Address:**_____

AUTHORIZATION TO PAY AND RELEASE INFORMATION:

I realize it is the <u>patient or guardian's responsibility</u> to be aware of what is/is not covered by my insurance. The contract of insurance is between me and my insurance company, and I should clarify benefits with my insurer if any questions. I am ultimately responsible for payment of the services provided me. I hereby assign all medical and/or surgical benefits for initial and follow-up Allergy & Asthma Center (AAC) visits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to AAC. This assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature of Patient: _____**Date:** _____