Allergy & Asthma Center
of Southern Oregon, PC
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Patient Information

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

Okay to Contact via Email for: ❑Appointments ❑Medications ❑Medical Records ❑Other _____
By Indicating that you would like to receive emails you are giving consent to send Personal Health Information (PHI) via Email and understand the risk of unencrypted 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:** _____ ❑Home ❑Cell

Ok to speak to ❑ **Emergency Contact** ❑ **Other:** _____ ❑**Medications** ❑ **Labs** ❑**Appts** ❑ **Billing**

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

Insurance Coverage

Primary Insurance Company Name: _____ **ID Number:**_____

Policy Holder:_____ **DOB:** _____ **Relationship to Patient:** _____
First M Last

Secondary Insurance Company Name: _____ **ID Number:**_____

Policy Holder:_____ **DOB:** _____ **Relationship to Patient:** _____
First M Last

AUTHORIZATION TO PAY AND RELEASE INFORMATION:

I realize it is the patient or guardian's responsibility 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/Financially Responsible: _____**Date:** _____