



# 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

Primary Phone: \_\_\_\_\_  Home  Cell Secondary Phone: \_\_\_\_\_  Home  Cell Email: \_\_\_\_\_

Okay to Contact via  Text  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

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  Home  Cell

Ok to speak to  Emergency Contact  Other: \_\_\_\_\_  Medications  Labs  Appts  Billing

## Insurance Coverage

Primary Insurance Company Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder:  Self  Other: \_\_\_\_\_ (If Other) DOB: \_\_\_\_\_  
First M Last

Relationship to Patient:  Self  Spouse  Other: \_\_\_\_\_ Insured Employer: \_\_\_\_\_

Secondary Insurance Company Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder:  Self  Other: \_\_\_\_\_ (If Other) DOB: \_\_\_\_\_  
First M Last

Relationship to Patient:  Self  Spouse  Other: \_\_\_\_\_ Insured Employer: \_\_\_\_\_

## Additional Information

Primary Care Doctor: \_\_\_\_\_ Primary Care Clinic: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Other \_\_\_\_\_

Patient's Language:  English  \_\_\_\_\_ Patient's Ethnicity:  Hispanic/Latino  Non-Hisp/Latino  Other \_\_\_\_\_

Patient's Race:  Caucasian  African American  Asian  American Indian  Hisp/Latino  Other \_\_\_\_\_  Unknown

## 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.

Printed name of Patient/Financially Responsible: \_\_\_\_\_

Signature of Patient/Financially Responsible: \_\_\_\_\_ Date: \_\_\_\_\_