Allergy & Asthma Center

of Southern Oregon, PC

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PATIENT INFORMATION

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

Mailing Address:_____
Street City State Zip Code

❑Home ❑Home

Primary Phone:_____❑Cell **Secondary Phone**:_____❑Cell **Email**:_____

Okay to Contact via ❑Text ❑Email for: ❑Appointments ❑Medications ❑Medical Records ❑Other_____

By including 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

❑Home

Emergency Contact:_____ **Relation**:_____ **Emergency Phone**:_____❑Cell

OK to speak to ❑Emergency Contact ❑Other:_____ about: ❑Medications ❑Labs ❑Appointments ❑Billing

INSURANCE INFORMATION (must be filled out)

Primary Insurance Company Name:_____

ID Number:_____ **Group Number**:_____

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 Number**:_____

Policy Holder: ❑Self ❑Other:_____ _____ _____ (If other) **DOB**:_____
First M Last

Relationship to Patient: ❑Self ❑Spouse ❑Other:_____ **Insured Employer**:_____

PERSON RESPONSIBLE FOR PATIENT (if patient is under 18)

Name:_____ _____ _____ **DOB**:_____
First M Last

Address (if different than patient):_____

❑Home

Relationship: ❑Mother ❑Father ❑Other:_____ **Phone**:_____❑Cell **Email**:_____

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-Hispanic Latino ❑Other:_____

Patient's Race: ❑Caucasian ❑African American ❑Asian ❑American Indian ❑Hispanic 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**:_____