Allergy & Immunology Medical Group

Office Use
Date:
Acct#:
Office:
PCP:

Patient Information

NAME (Last, First, Middle)	BIRTHDATE	MARITAL STATUS	SEX

LOCAL ADDRESS	CITY	STATE	ZIP

SECONDARY / BILLING ADDRESS (IF APPLICABLE)	CITY	STATE	ZIP

HOME PHONE NUMBER	CELL PHONE NUMBER

E-MAIL ADDRESS	EMERGENCY CONTACT NAME	PHONE NUMBER

Patient Employer Information (if applicable)

EMPLOYER

ADDRESS

CITY, STATE, ZIP

WORK PHONE

Responsible Party Information (if minor, parent information)

NAME (Last, First, Middle)	BIRTHDATE	MARITAL STATUS	SEX

LOCAL ADDRESS	CITY	STATE	ZIP

HOME PHONE NUMBER	CELL PHONE NUMBER

EMPLOYER	WORK PHONE NUMBER

Primary Insurance

NAME OF INSURANCE COMPANY	POLICY OR MEMBER ID NUMBER (SS# IF TRICARE)	

NAME OF INSURED	DATE OF BIRTH	GROUP NUMBER

EMPLOYER	RELATIONSHIP TO PATIENT

COPAY AMOUNT	EFFECTIVE DATE OF POLICY	Branch of Service (if Applicable)

Secondary Insurance (if applicable)

NAME OF INSURANCE COMPANY	POLICY OR MEMBER ID NUMBER (SS# IF TRICARE)	

NAME OF INSURED	DATE OF BIRTH	GROUP NUMBER

EMPLOYER	RELATIONSHIP TO PATIENT

COPAY AMOUNT	EFFECTIVE DATE OF POLICY	Branch of Service (if Applicable)

Minor Treatment Consent: I give Allergy & Immunology Medical Group permission to treat _____ in my absence. Signature: _____

FINANCIAL POLICY: Payment is expected at the time of service. Services provided which are not a covered benefit of your health plan will be your responsibility. There will be a $15.00 service charge for all returned checks.
CONSENT TO TREATMENT/RELEASE INFORMATION: I grant Allergy & Immunology Medical Group permission to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information necessary to process insurance claims.
ASSIGNMENT OF BENEFITS: I authorize all benefits payable by my insurance company to Allergy & Immunology Medical Group.

Signature of Patient/Guardian Date:

Methods of Communication

In compliance with HIPAA regulations, I request the use of the following method(s) of communication regarding information related to my personal health, treatment or payment for treatment. I acknowledge that I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.

***Contact me by telephone at:**

Home Phone: ( )_____

Work Number: ( )_____

Cell Number: ( )_____

* May we leave a message concerning your health/test results on your home answering machine/voice mail?

Yes_____ No _____

* May we contact you by e-mail concerning your health/test results?

Yes_____ No _____

E-mail address: _____

* To whom may we speak in your household?

_____ Anyone who answers the telephone.

_____ Specify: _____

*If you have left a work number above, may we leave a message?

Yes_____ No _____

Date: _____ Patient Signature:_____

We would like to inform you of our office policy regarding missed appointments and late arrivals.

If there is a late cancellation (less than 24 hours in advance) or if a patient fails to show up for a scheduled appointment, there will be a charge to the account of $45.00. Insurance will not cover charges for no show or late cancellations.

If a patient is late for appointment (30 minutes or more) the appointment will have to be rescheduled.

“No shows” and late cancellations inconvenience patients who need access to medical care in a timely manner. Please be courteous and call the office at least 24 hours in advance if it is necessary to cancel your scheduled appointment. This time will allow us to schedule another patient.

Call 760-941-4444. If you call after hours, please leave a message or speak to someone at our answering service. We will return your call and if you would like to reschedule, we will give you the next available appointment.

I have read the above and agree to abide by the policy as stated

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Patient Name Printed

Patient or Parent Signature

(relationship to Patient)_____

Date:_____