PATIENT INFORMATION

FORT WAYNE Allergy & Asthma CONSULTANTS, INC

TODAY'S DATE: _____ Phone: 260-436-5670

LAST NAME:	FIRST NAME:	M.I.	BIRTH DATE	SEX

IF PATIENT IS A MINOR, LIVES WITH:	RELATIONSHIP

MARITAL STATUS OF PATIENT (Select One) ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated	SSN OF PATIENT

STREET ADDRESS	PRIMARY PHONE NUMBER

CITY	STATE	ZIP CODE	ALTERNATE PHONE NUMBER

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE NUMBER	EMAIL

PATIENT'S EMPLOYER	OCCUPATION	WORK PHONE NUMBER

PATIENT'S EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST WITH THIS FORM

PRIMARY INSURANCE COMPANY	EFFECTIVE DATE	POLICY HOLDER'S NAME	POLICY HOLDER'S SSN	POLICY HOLDER'S DOB

ID #	GROUP #	EMPLOYER'S NAME	TO HOLDER, PATIENT IS: ☐ Self ☐ Child ☐ Spouse ☐ Other

INSURED PARTY'S ADDRESS

SECONDARY INSURANCE COMPANY	EFFECTIVE DATE	POLICY HOLDER'S NAME	POLICY HOLDER'S SSN	POLICY HOLDER'S DOB

ID #	GROUP #	EMPLOYER'S NAME	TO HOLDER, PATIENT IS: ☐ Self ☐ Child ☐ Spouse ☐ Other

INSURED PARTY'S ADDRESS

ANY IMMEDIATE FAMILY MEMBER A PATIENT AT THIS OFFICE?

RESPONSIBLE PARTY (Select One) ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ GUARDIAN ☐ SELF

LAST NAME	FIRST NAME	M.I.	PHONE	BIRTHDATE

ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER'S NAME	PHONE NUMBER	SSN

EMPLOYERS ADDRESS	CITY	STATE	ZIP CODE

PRIMARY CARE PHYSICIAN	CITY

REFERRING PHYSICIAN	CITY

PATIENT INFORMATION

FORT WAYNE Allergy & Asthma CONSULTANTS, INC

PLEASE SIGN ALL THREE AREAS BELOW

CONSENT TO TREATMENT

I hereby voluntarily consent and authorize Fort Wayne Allergy and Asthma Consultants, Inc., through its providers, to perform diagnostic procedures and medical treatment as deemed necessary by the provider. I acknowledge that no guarantees have been made to me as to the result of this treatment. This authorization shall remain in effect indefinitely, unless specifically amended by the patient or legal guardian.

_____	_____	_____	_____
Date	Signature of Patient of Legal Guardian	Date	Signature of Other Parent or Legal Guardian

AUTHORIZATION TO RELEASE INFORMATION AND AGREEMENT TO PAY

I hereby voluntarily consent and authorize Fort Wayne Allergy and Asthma Consultants, Inc., to release any information acquired in the course of the patient's examination or treatment to process insurance claims. In consideration of services rendered and to be rendered by Fort Wayne Allergy and Asthma Consultants, Inc., I agree to pay for all services performed and ordered by the attending provider. I also agree to pay reasonable attorney fees and legal expenses, as permitted by applicable law, incurred in connection with this account. This authorization shall remain in effect indefinitely unless specifically amended by the patient or legal guardian.

_____	_____	_____	_____
Date	Signature of Patient of Legal Guardian	Date	Signature of Other Parent or Legal Guardian

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby assign to Fort Wayne Allergy and Asthma Consultants, Inc., benefits which are due or are to become due to me as a result of medical services for the said patient. I hereby authorize the payments to be made directly to Fort Wayne Allergy and Asthma Consultants, Inc. I understand that I am financially responsible for any portion of the charges for medical services, which for any reason, are not paid by my Insurance Company. I hereby give permission to Fort Wayne Allergy and Consultants, Inc. to contact my insurance carrier to facilitate the process of my claim. This authorization shall remain in effect indefinitely unless specifically amended by the patient or legal guardian.

_____	_____	_____	_____
Date	Signature of Patient of Legal Guardian	Date	Signature of Other Parent or Legal Guardian