ALLERGY & ASTHMA SPECIALISTS, P.C.

PATIENT INFORMATION

Patient Name:	**Sex:** ☐ Male ☐ Female
Patient's DOB:	**Age:**
Address:	**Home Phone:** **Cell Phone:** **Work Phone:**
Email address:	**How may we best contact you?:**
Marital Status: ☐ Married ☐ Divorced ☐ Single	☐ Home phone ☐ Cell phone ☐ Email
Race: ☐ White/Caucasian ☐ American Indian ☐ African American ☐ Asian ☐ Asian/Pacific Islander ☐ More than one race ☐ Other: **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Other: ☐ Refuse to report **Preferred Language:** ☐ English ☐ Spanish ☐ Other:	

CARE TEAM

Pediatrician: **Phone #:**	**Primary Care Physician:** **Phone #:**	**Referring Physician (if different):** **Phone#:**

EMERGENCY CONTACT INFORMATION

Name:	**Relationship:**	**Phone #:**

82 East Allendale Road, Suite 7, Saddle River, NJ 07458 Tel (201) 236-8282 Fax (201) 236-0138
www.njallergydoctors.com

ALLERGY & ASTHMA SPECIALISTS, P.C.

INSURANCE INFORMATION

Primary Insurance Company:	Subscriber (name of insured):	Relationship:	Birth Date:
Insured ID:		Policy/Group #:	
Secondary Insurance Company:	Subscriber (name of insured):	Relationship:	Birth Date:
Insured ID:		Policy/Group #:	

GUARANTOR INFORMATION

(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT'S ACCOUNT) **(IF DIFFERENT THAN ABOVE)**

First Name:	**Middle Initial:**	**Last Name:**
Address:	**Relationship:** Mother ☐ Father ☐ Other:	**Home Phone:** **Cell Phone:**
Birth Date:	**Email Address:**	

RELEASE OF INFORMATION

I authorize the release of any information necessary to process insurance claims. I also authorize payment of benefits to Allergy & Asthma Specialists, P.C. I authorize your office to leave messages on my telephone machine/voicemail for numbers listed above.

Name: _____ Date: _____

Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY

All co-payments are due at time of service. I understand that certain charges may not be covered by my insurance and I am financially responsible for all charges incurred. If a referral is required by my health insurance plan, I understand that the referral must be valid and completed with the provider name. I understand that I will be held responsible for the cost of services provided if I do not present a valid referral. I permit a copy of this release to be used in place of the original.

Signature: _____ Date: _____

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