Allergy & Asthma Centers, P.C.

Dependent Information

Patient Name ____M_____ F_____

Birthdate _______________ SS# ______________________ Phone # (_____) _____________________

Street Address ______________________________________ Apt. _____ CELL # ____________________

City ____ State ________ Zip ___________________

Primary Care Physician ________________________________ Phone # (_____) _____________________

Address ____State _______________ Zip ___________

Father Name __________________________________ Birthdate _________ SS# ________________________

Street Address (if different) ____ Apt. __________________

City _________________________________ State ____ Zip ________ Phone (_____) _______________

Employer ____ Work Phone (_____) ____________________

Work Address ____

City ____State ___________ Zip ______________________

Mother Name ______________________________ Birthdate ____________ SS# _______________________

Street Address (if different) ______________________________________ Apt. ___________________

City _________________________________ State _____ Zip _______ Phone (_____) _______________

Employer ____ Work Phone (______) ____________________

Work Address ________________________ City ___________________ State _______ Zip ___________

Please tell us who referred you to our practice ____

Primary Insurance _______________________________________ ID# _______________________________

Group # ______________________________ Who Carries Coverage _______________________________

Secondary ____ ID# _____________________________

Group # ______________________________ Who Carries Coverage _______________________________

Relative (or friend) _______________________________________ Phone # (______) ___________________

Please provide us with your **Pharmacy Name** _________________ **& Number** __________________________

I authorize payment of medical benefits to Allergy & Asthma Centers, P.C. and release of any medical information necessary to process these benefits. I take full responsibility for any unpaid balance for me or my dependents including any collection costs, court costs, or attorney fees necessary.

Signature ____ **Date** ______________________________