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 _____

Patient / Guardian Email Address _____

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** _____