ALLERGY & ASTHMA CENTERS, P.C.

ADULT INFORMATION			
Patient Name:		**Male**	**Female**
Date of birth:	**SSN:**	**Home Phone:**	
Current address:		**Cell Phone:**	
City:	**State:**	**ZIP Code:**	
Email Address:			
Current employer:			
Referred By:		Phone:	
Primary Care Physician:		Phone:	
Spouse Name (if applicable)		Birthdate:	
Street Address (if different)		Apt:	
City:	State & Zip:	Phone:	
Spouse Employer:		Work Phone:	
Work Address:			
City:	State & Zip:	SS#:	
Please tell us who referred you to our practice:			

INSURANCE	
Primary Insurance:	ID #:
Group #	Who Carries Coverage:
Secondary Insurance:	ID#
Group #	Who Carries Coverage:
Relative (or friend)	Phone:
Pharmacy Name:	Phone:

SIGNATURE	
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: