ALLERGY & ASTHMA CENTERS, P.C.

DEPENDENT INFORMATION

Patient Name:		Male	Female
Date of birth:	SSN:	Home Phone:	
Current address:		Cell Phone:	
City:	State:	ZIP Code:	
Patient or Guardian email address:			
Primary Care Physician:	Phone Number:		

FATHER INFO

Name:	Birthdate:	SSN:
Current address (if different):		Apt:
City:	State & Zip Code:	Home Phone:
Employer:	Work Address:	State & Zip Code:
Work City:	Work Phone:	Cell Phone:

MOTHER INFO

Name:	Birthdate:	SSN:
Current Address (if different):		Apt:
City:	State & Zip Code:	Home Phone:
Employer:	Work Address:	State & Zip Code:
Work City:	Work Phone:	Cell Phone:

INSURANCE INFO

Primary Insurance:	ID#:
Group #:	Who Carries Coverage:
Secondary Insurance:	ID#:
Group #:	Who Carries Coverage:

REFERENCES

Please tell us who referred you to our practice:		
Relative (or friend):	Phone Number:	

PHARMACY

Please provide us with your **Pharmacy**	Name:
	Phone Number:

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:**