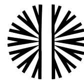

CONSULTANTS IN
ALLERGY & ASTHMA CARE

1160 Park Avenue West, Suite 3 South, Highland Park, Illinois 60035 office 847.432.0200 fax 847.432.0201
www.allergyasthmacare-doctor.com

PATIENT REGISTRATION FORM

*** = REQUIRED INFORMATION**

(*PLEASE PRINT CLEARLY*)

Today's Date: ____________ E-mail: ____________________
(Month/Day/Year)

***Patient's Name**: ______________________________________
*(Last) *(First) (Middle Initial)

***Address**: ______________________________________
*(Street) *(City) *(State) *(Zip)

***Date of Birth**: ____________ Age: ________ ***Sex**: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ W ❑ D
*(Month/Day/Year)

*Home #: (_____) __________ ❑ Work #: (_____) __________ ext _____ ❑ Cell # (_____) __________ ❑
(Please indicate √ which phone number above we should use as your PRIMARY contact number – THANK YOU)

***Referring Physician**: ______________________________________
*(Name) *(Address) *(Phone)

~ Referring Physician will receive a consultation letter for your initial visit. If NONE, please write NONE. ~

Referred By: ______________________________________
(Name) (Address) (Phone)

Are any members of your family, patients of Consultants in Allergy and Asthma Care? ❑ Yes ❑ No ____________
(Name)

Name of Spouse/Parent: ______________________________________
(Name) (Address)

*Guarantor for Bill: ______________________________________
**(Name)* **(Address)* **(Social Security #)*

Guarantor Employer: ______________________________________
(Name) (Address) (Phone)

***Primary Insurance Company**: ____________________ ***Group & ID #'s**: ________/____________
*(Carrier Name) *(Group) *(ID #)

***Claims Mailing Address**: ______________________________________

***Policy Holder Name:** ______________________________ ***Date of Birth:** _____/_____/________

***Secondary Insurance Company**: ____________________ ***Group & ID #**: ________/____________
*(Carrier Name) *(Group) *(ID #)

***Claims Mailing Address**: ______________________________________

***Policy Holder Name:** ______________________________ ***Date of Birth:** _____/_____/________

~ We will require a copy of ALL valid insurance cards to submit your claims. ~

I hereby authorize my insurance benefits to be paid directly to the above-assigned physicians for today's and all future services. Realizing I am responsible to pay any non-covered services. I hereby authorize the release of pertinent medical information to my insurance carrier(s).

X______________________________ ____________
Patient Signature / Guarantor Date

THANK YOU FOR CHOOSING CONSULTANTS IN ALLERGY AND ASTHMA CARE, LLC

PLEASE COMPLETE THE OTHER SIDE OF THIS DOCUMENT.