CONSULTANTS IN
ALLERGY & ASTHMA CARE

*** REQUIRED INFORMATION**

PATIENT REGISTRATION FORM

(PLEASE PRINT CLEARLY)

PATIENT INFORMATION			
Today's date:	Email:		
***Patient's Name:** (Last)	(First)	(Middle Initial)	
***Address:** (Street)	(City)	(State)	(Zip)
***Date of Birth:** (Month/Day/Year) **Age:**	***Gender Identity:** ❑ M ❑ F ❑ Non-Binary	Marital Status: ❑ S ❑ M ❑ W ❑ D	
***Home #:** (____) _____❑ **Cell #:** (____) _____ ❑ **Work #:** (____) _____Ext: ____❑ (Please indicate ✓ which phone number above we should use as your **PRIMARY contact number**)			
***Referring Physician:** (Name) (Address) (Phone) **-Referring physician will receive a consultation letter for your initial visit. If NONE, please write NONE**.-			
Referred By: (Name)	Are any members of your family patients of Consultants in Allergy & Asthma Care? ❑ Yes ❑ No If Yes, (Name):		
Emergency Contact: (Name)	**Relationship to Patient:**	**Phone Number:**	
Name of Spouse/Parent:	Address: (If different from above):		

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR BILL AFTER INSURANCE)			
***❑ SELF or Guarantor Name:**	Address:	*Relationship to Patient:	*Date of Birth:
*Guarantor SSN:	Email Address:	*Phone Number:	

SUBSCRIBER/INSURANCE INFORMATION (PERSON WHO HOLDS THE INSURANCE POLICY)			
***❑ SELF or Subscriber Name:**	*Date of Birth	*Address (If different than above):	
Subscriber SSN:	*Relationship to Patient:	*Phone Number:	

PRIMARY INSURANCE COMPANY **(EVEN THOUGH WE HAVE A COPY OF YOUR INSURANCE CARD, WE REQUIRE THE BELOW INFORMATION TO BE COMPLETED)**		
*** Name of Insurance Company:**	***ID #:**	***Group #:**
SECONDARY INSURANCE COMPANY		
*** Name of Insurance Company:**	***ID #:**	***Group #:**
***Subscriber Name (If different than above):**		
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 physician 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-

Updated: 12/10/22