



CONSULTANTS IN
ALLERGY & ASTHMA CARE

PATIENT REGISTRATION FORM
(PLEASE PRINT CLEARLY)

* REQUIRED INFORMATION

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: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Non-Binary	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D
*Home #: _____ <input type="checkbox"/> Cell #: _____ <input type="checkbox"/> Work #: _____ Ext: _____ <input type="checkbox"/> (Please indicate <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)			
* <input type="checkbox"/> 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)			
* <input type="checkbox"/> 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 for charges, which are not covered or denied by my insurance. I hereby authorize the release of pertinent medical information to my insurance carrier(s).			
_____ Patient Signature or Parent/Guardian (if minor)		_____ Date	

THANK YOU FOR CHOOSING CONSULTANTS IN ALLERGY AND ASTHMA CARE, LLC
-PLEASE COMPLETE THE OTHER SIDE OF THIS DOCUMENT-