

Pikes Peak Allergy and Asthma, LLC

Patient Information

Date _____

New Patient **Name Change** **Address Change** **Insurance Change**
(CIRCLE ONE)

Patient Name: _____ Married or Single
First *M.I* *Last*

Date of Birth: _____ Age _____ SS#: _____ Male or Female

Mailing Address: _____ Zip _____

Home Phone:(_____) _____ Cell Phone:(_____) _____

Employer: _____ Occupation: _____ WK Phone: _____

Race: CAUCASIAN AFRICIAN- AMERICAN HISPANIC ASIAN OTHER

***EMERGENCY CONTACT:** _____ / _____ **Phone:** _____
(Name and relationship to Patient)

PRIMARY CARE PHYSICIAN: _____
Name

Address / *Phone*

***How did you hear about our office?** _____

Insurance Coverage:

Primary:

Insurance Company Name: _____

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: _____

Policy Holder (Insured) ID Number: _____ GROUP _____

Secondary:

Insurance Company Name: _____

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: _____

Policy Holder (Insured) ID Number: _____ GROUP _____

By signing I am stating that the above information is true. I authorize Pikes Peak Allergy & Asthma to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to Pikes Peak Allergy & Asthma for services rendered.

I am responsible to pay non-covered services. Claims not paid by Insurance Company after 60 days will be forwarded to me for payment.

SIGNATURE (Patient or Guardian)

RELATIONSHIP TO PATIENT

DATE