

## PATIENT REGISTRATION / UPDATE

Appt. Date: \_\_\_\_\_ Dr. \_\_\_\_\_ Chart No: \_\_\_\_\_

Please print information requested within space provided. Form must be current and complete for us to process insurance claims without delay or possible denial.

P A T I E N T	Have you or any other family member been treated in this office? Yes <input type="checkbox"/> No <input type="checkbox"/> Name: _____				
	Name: _____ Age: _____				
	Last	First	MI	Nickname	
	Social Security # _____		Maiden/Former Name: _____		
	Sex: M <input type="checkbox"/>	F <input type="checkbox"/>	Date of Birth: _____	Marital Status:	S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> Sep <input type="checkbox"/>
	Home Address: _____			Phone: _____	
	City: _____		State: _____	Zip Code: _____	
	E-mail address: _____				
	Employer: _____		Occupation: _____	Yrs Employed _____	
	Employer Address: _____		Work Phone: _____		
City: _____		State: _____	Zip Code: _____		
Primary Care Physician: _____		Address: _____			
Phone: _____		What physician requested you be seen in this office? _____			

R E S P O N S I B L E	Primary Insurance: _____		Secondary Insurance: _____		
	Address: _____		Address: _____		
	Phone: _____		Phone: _____		
	ID# _____		ID# _____		
	Group: _____	Plan# _____	Group: _____	Plan# _____	
	Effective Date: _____		Effective Date: _____		
	Insured's Name: _____		Insured's Name: _____		
	Insured's SSN: _____		Insured's SSN: _____		
	Insured's Birthdate: _____		Insured's Birthdate: _____		
	Relationship to Patient: _____		Relationship to Patient: _____		
	Insured's Employer: _____		Insured's Employer: _____		
	Employer Address: _____		Employer Address: _____		
	Employer Phone: _____		Employer Phone: _____		
	Insured's Address: _____		Insured's Address: _____		
City	State	Zip	City	State	Zip

I authorize treatment of the person(s) named above and agree to pay all fees and charges for such treatment. I understand that all charges, co-payments, and deductibles determined to be patient responsibility will be charged to the patient. I authorize payment of insurance benefits directly to Asthma & Allergy Associates, P.C. for any service rendered me by Robert A. Nathan, M.D.; William W. Storms, M.D.; or Geeta Khare, M.D. I hereby authorize release of medical information needed to complete insurance claim inquiries.

As a present or future member of a Health Maintenance Organization (HMO) or other third party payor, I recognize that I may be required by that HMO to receive a Primary Care Physician's (PCP) referral prior to being treated by the specialist providers at Asthma & Allergy Associates, P.C. (AAAPC). I also recognize that it is my responsibility, not the responsibility of AAAPC, to obtain this referral. If I do not obtain a referral I understand that I am circumventing my health care plan and as such understand the HMO may not be required to pay for services rendered. In such cases, I agree to accept full financial responsibility for any direct or ancillary charges related to the services rendered without a referral.

\_\_\_\_\_  
Signature (Parent/Guardian if patient is under 18)

\_\_\_\_\_  
Date