Family Allergy, Asthma, Immunology, & Sinus Center P.C.

15644 Pomerado Road, Suite 204 Poway Ca. 92064
Phone: (858) 521- 0806 Fax: (858) 521-0808
www.familyallergy.org

OFFICE USE	
DATE:	**ACCT#:**
PRIMARY DOCTOR:	
REF DOCTOR:	
PHARMACY:	

PATIENT INFORMATION				MARITAL STATUS:
NAME (LAST, FIRST, MIDDLE):	BIRTHDATE:	SEX:		SOCIAL SECURITY #:
LOCAL ADDRESS (NO P.O. BOXES):		CITY:	STATE:	ZIP:
SECONDARY/BILLING ADDRESS (IF APPLICABLE):		CITY:	STATE:	ZIP:
HOME NUMBER:	WORK NUMBER:		CELL NUMBER:	
EMAIL:	EMERGENCY CONTACT:		PHONE NUMBER:	

PATIENT EMPLOYER INFORMATION (if applicable)	
EMPLOYER:	ADDRESS:

SPOUSE OR PARENT INFORMATION				
NAME (LAST, FIRST, MIDDLE):	BIRTHDATE:	SEX:	MARITAL STATUS:	
LOCAL ADDRESS:		CITY;	STATE:	ZIP:
HOME PHONE NUMBER:	CELL PHONE NUMBER:	EMPLOYER:	WORK NUMBER:	

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY:		POLICY MEMBER ID # (SS# IF TRICARE)	
NAME OF INSURED:		DATE OF BIRTH:	GROUP NUMBER:
EMPLOYER:	RELATIONSHIP TO PATIENT:	COPAY AMOUNT:	EFFECTIVE DATE OF POLICY:

SECONDARY INSURANCE (if applicable)			
NAME OF INSURANCE COMPANY:		POLICY OR MEMBER ID # (SS# IF TRICARE)	
NAME OF INSURED:		DATE OF BIRTH:	GROUP NUMBER:
EMPLOYER:	RELATIONSHIP TO PATIENT:	COPAY AMOUNT:	EFFECTIVE DATE OF POLICY:

FINANCIAL POLICY: PAYMENT IS EXPECTED AT TIME OF SERVICE. SERVICES PROVIDED WHICH ARE NOT A COVERED BENEFIT OF YOUR HEALTH PLAN WILL BE YOUR RESPONSIBILITY. THERE WILL BE A $25.00 SERVICE CHARGE FOR ALL RETURNED CHECKS. THERE WILL BE A 30% SURCHARGE FOR ANY ACCOUNTS SENT TO COLLECTION. INITIAL__________.

CONSENT TO TREATMENT/RELEASE INFORMATION: I GRANT FAMILY ALLERGY, ASTHMA, IMMUNOLOGY & SINUS CENTER P.C. PERMISSION TO ADMINISTER MEDICAL TREATMENT AND PERFORM MEDICAL PROCEDURES AS DEEMED NECESSARY. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS.

ASSIGNMENT OF BENEFITS: I AUTHORIZE ALL BENEFITS PAYABLE BY MY INSURANCE COMPANY TO FAMILY ALLERGY, ASTHMA, IMMUNOLOGY & SINUS CENTER P.C.

MINOR TREATMENT CONSENT: I GIVE FAMILY ALLERGY, ASTHMA, IMMUNOLOGY & SINUS CENTER P.C., and PERMISSION TO TREAT __________________IN MY ABSENCE.

SIGNATURE OF PATIENT/GUARDIAN: DATE: