AVANT ALLERGY & ASTHMA

PATIENT INFORMATION

First Name: _____ M.I.: _____ Last name: _____

Date of Birth: _____ Age: _____ Sex: □ Male □ Female □ Other: _____

Billing Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ E-mail Address: _____

Primary Care Physician Name: _____ Phone Number: _____

Referring Physician Name: _____ Phone Number: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

PRIMARY INSURANCE (please bring insurance card to visit)

Insurance Provider: _____ Member ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder SSN: _____ Policy Holder DOB: _____

Insurance Co. Address: _____ Insurance Co. Phone #: _____

SECONDARY INSURANCE (please bring insurance card to visit)

Insurance Provider: _____ Member ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder SSN: _____ Policy Holder DOB: _____

Insurance Co. Address: _____ Insurance Co. Phone #: _____

AUTHORIZATION AND ATTESTATION

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. This information is on file as a permanent record and may be amended if necessary.

I hereby assign to Avant Allergy & Asthma any insurance or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned by contractual agreement, payment to the practice will be made by any insurance. I acknowledge that I am responsible for any co-payments, co-insurance payments, and deductibles. These amounts are due at the time services are rendered. I understand that in the event that services rendered are not covered by my insurance, I will accept financial responsibility for all services provided to me.

I authorize the release of any medical information or other information as is necessary to process this claim. This is in compliance with the HIPAA Notice of Privacy Practice, which I attest to reading.

Responsible party signature: _____ Date: _____

Print name: _____ Relationship (if other than self): _____