

PLEASE PRINT

PATIENT REGISTRATION FORM

PATIENT:

MR.
MRS.
MISS

LAST FIRST MIDDLE AGE DATE OF BIRTH

SEX M F

MARITAL STATUS SOCIAL SECURITY NO. DRIVER'S LICENSE NO.

ADDRESS STREET CITY STATE ZIP

EMPLOYER OCCUPATION INDICATE IF STUDENT

EMPLOYER'S ADDRESS STREET CITY STATE ZIP

SPOUSE OR PARENTS NAME S.S NO.

SPOUSE OR PARENTS EMPLOYER OCCUPATION

EMPLOYER'S ADDRESS STREET CITY STATE ZIP

WHY DID YOU CHOOSE DR. MILLER? (Please Complete)

REFERRAL SOURCES: SELF YELLOW PAGES FRIEND NAME PHYSICIAN

BILL TO:

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE

ADDRESS STREET CITY STATE ZIP

HOME PHONE

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE ADULT

INSURANCE INFORMATION:

#1 PRIMARY INSURANCE CO./MEDICARE/MEDICAID PLAN I.D. NO. GROUP NO.

INSURANCE COMPANY ADDRESS SUBSCRIBER

#2 SECONDARY INSURANCE COMPANY NAME I.D. NO. GROUP NO.

INSURANCE COMPANY ADDRESS SUBSCRIBER

METHOD OF PAYMENT:

CASH CHECK MASTER CARD/VISA OTHER

LONG TERM INSURANCE AUTHORIZATION:

I AUTHORIZE DR. MILLER TO FURNISH TO INSURANCE CARRIERS ANY INFORMATION NECESSARY TO PROCESS MY CLAIMS. I AGREE TO PAY ALL CHARGES FOR ME AND MEMBERS OF MY FAMILY SHOWN BY STATEMENTS, PROMPTLY UPON PRESENTATION THEREOF, UNLESS OTHER ARRANGEMENTS ARE AGREED UPON UNDER CERTAIN CIRCUMSTANCES WHEREBY INSURANCE CLAIMS ARE SUBMITTED BY ALLERGY, ASTHMA & IMMUNOLOGY, P.C. ON MY BEHALF, I AUTHORIZE PAYMENT OF SUCH BENEFITS TO ALLERGY, ASTHMA & IMMUNOLOGY, P.C.

DATE SIGNATURE (RESPONSIBLE PARTY)

HOME PHONE BUSINESS PHONE IF NONE, NUMBER OF NEAREST PHONE