ADAC
ALLERGIC DISEASE & ASTHMA CENTER, P.A.

PATIENT INFORMATION

DATE _____ Email Address _____

Patient _____ Date of Birth _____
Last First Middle

Address _____ Employer _____
Street

_____
City State Zip Spouse's Name _____

Contact Phone _____ Spouse's Employer _____

Social Security No. _____

Marital Status _____

RACE (circle one): American Indian or Alaska Native, Asian, Native Hawaiian, Black/African American, White/Caucasian, Hispanic, Other
Ethnicity (circle one):Hispanic or Latino, Not Hispanic or Latino, Refused to Report
Language (circle one): English, Indian (includes Hindi), Spanish, Russian, Other

Person Responsible for bill _____

Address _____ Home Phone _____

_____ Work Phone _____

In Case of Emergency Contact: _____ Phone _____

Referring Physician's Name _____

Primary Physician's Name _____

Pharmacy _____ Address _____ Phone _____

PRIMARY INSURANCE COVERAGE

Insured Name DOB _____

ID# _____ Group# _____

Company _____

Address _____

_____

SECONDARY INSURANCE COVERAGE

Insured Name DOB _____

ID# _____ Group# _____

Company _____

_____

_____

FOR MINOR CHILDREN, PLEASE COMPLETE THE FOLLOWING:

Father _____ Phone No. _____

Address _____ Father's Birthdate _____ SS#: _____

_____ Employer _____

Phone No. _____

Mother _____ Mother's Birthdate _____ SS#: _____

Address _____ Employer _____

_____

Home Work

I understand that I may be subject to charges for appointments not cancelled 24 hours in advance.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly to Allergic disease and Asthma Center, P.A. of the Medical Benefits, if any, other wise payable to me for their service. I also authorize Allergic Disease and Asthma Center, P.A. to release any information acquired in the course of treatment for insurance purposes. I understand that responsibility for payment lies solely with me.