PATIENT REGISTRATION FORM

INFORMATION ON THE PERSON BEING SEEN TODAY

Patient's Name (First, Middle Initial, Last):_____
Address: _____
City: State: Zip: _____
Home Phone: _____ Cell Phone: _____
Date of Birth: _____ /_____ /_____ Sex: _____ Male _____ Female
Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed _____ Unknown
Social Security Number: _____ E-mail: _____
Race/Ethnicity**:** ____White/Caucasian ____ Non-Hispanic/Non-Latino ____ Black/African American
____ Hispanic/Latino_____Other
Preferred Language: ____ English ____ Spanish ____ Other_____
Preferred Contact Method: _____Email_____Cell_____Home_____Text_____Work
Pharmacy name/location_____
How did you hear about our practice? _____Word of Mouth _____Referral _____Website
_____Social Media _____Insurance _____Other:_____
PCP:_____

INFORMATION ON THE PERSON RESPONSIBLE FOR PATIENT

Responsible Person's Name (First, Middle Initial, Last): _____
Date of Birth: _____ /_____ /_____ Sex: _____ Male _____ Female
Social Security Number: _____ E-mail: _____
Address: _____
City: State: Zip: _____
Home Phone: _____ Cell Phone: _____
Emergency contact (and Relationship):_____
Home Phone:_____
Address (if different from above):_____

INSURANCE INFORMATION:

******** Please allow the receptionist to make copies of your insurance cards********

PLEASE NOTE: It is the policy of ***Breathe Better Allergy Asthma and Sinus Center*** that we collect full payment at the time of your visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. Please understand that if you are not with a ***contracted*** carrier, you must pay for your visit at time of service. If you have a concern about your ability to pay for the services in full, please speak with the receptionist at time of service.

PRIMARY INSURANCE CARRIER:
Name of Policyholder: _____ Policyholder's DOB: _____ /_____ /_____
Policyholder's Employer: _____Policyholder's SS#: _____
Policyholder's Relationship to patient: _____

SECONDARY INSURANCE CARRIER:

Name of Policyholder: _____ Policyholder's DOB: _____ /_____ /_____
Policyholder's Employer: _____ Policyholder's SS#: _____
Policyholder's Relationship to patient: _____

I authorize ***Breathe Better Allergy Asthma and Sinus Center*** to release to my insurance company any information required for services provided. I authorize payment of Medical Benefits to ***Breathe Better Allergy Asthma and Sinus Center***

I understand that I remain responsible to ***Breathe Better Allergy Asthma and Sinus Center*** for any and all charges.

Authorization and Assignment:
I authorize ***Breathe Better Allergy Asthma and Sinus Center*** *to release medical records to my employer or any insurance company with whom I have medical benefits for the purpose of filing medical claims. I also authorize any physician, hospital, or clinic to provide medical information required in the course of my examination or treatment.* ***I give consent for Breathe Better Allergy Asthma and Sinus Center physicians to obtain Rx history from external sources.***

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative.

Insurance is filed as a courtesy. It is the patient/guardian responsibility to ensure all bills are paid. All co-pays, deductibles, and co-insurance are due at the time of services.

Assignment of Benefits Payment:
I authorize my health insurance benefit plan to pay directly to ***Breathe Better Allergy Asthma and Sinus Center***. I understand that I am financially responsible to ***Breathe Better Allergy Asthma and Sinus Center*** for any non-covered charges. If I am a self-pay patient, I understand that I am responsible for all charges in full at the time of service

Signature: _____

Date:_____