**THE ALLERGY AND ASTHMA CENTER**
7222 ENGLE RD, FORT WAYNE, IN 46804 10415 LEO RD, FORT WAYNE, IN 46825
2280 PROVIDENT CT. #A, WARSAW, IN 46580
(260) 432-5005 — FAX: (260) 432-6003
www.AllergyAsthmaCenter.com

## PATIENT INFORMATION

☐ **Mr.**
☐ **Mrs.**
☐ **Miss**
☐ **Ms.**

PLEASE FILL OUT COMPLETELY

Date _____

Name _____
*PLEASE PRINT FIRST MIDDLE LAST*

Address _____ SSN# __ __ __-__ __-__ __ __ __

City _____ State _____ Zip _____

Sex: M F Date of Birth ____/____/____ Race_____ Ethnicity_____ Language_____

E-Mail _____ Family Doctor *(first and last)* _____

Home Phone (___)_____ Cell Phone (___)_____ Work Phone (___)_____

In case of emergency who should be notified? _____ Relation _____

Home Phone (___)_____ Work Phone (___)_____ Cell Phone (___)_____

Whom can we thank for referring you to our office? _____

**How did you hear about our office?** (Check all that apply)

☐ Referred by a Doctor ☐ Referred by a Patient ☐ Yellow Pages ☐ Newspaper ☐ Website ☐ Insurance Company ☐ TV
☐ Medical Recommendation ☐ Pharmacist ☐ Dr Smits' Lecture ☐ Referred by a Staff Member ☐ Other _____

If patient is less than 18 years of age:

| | ☐ **Mrs.** ☐ **Miss** ☐ **Ms.** |
|---|---|
| Father's Name _____ | Mother's Name _____ |
| SSN#__ __ __-__ __-__ __ __ __D.O.B. ___/___/_____ | SSN# __ __ __-__ __-__ __ __ __ D.O.B___/___/_____ |
| Address _____ | Address _____ |
| _____ | _____ |
| Home Phone (____)_____ | Home Phone (____)_____ |
| Work Phone (____)_____ | Work Phone (____)_____ |
| Cell Phone (____)_____ | Cell Phone (____)_____ |
| Employer _____ | Employer _____ |

## ACCOUNT INFORMATION

**Adult Responsible for Payment (Please Print)**_____

Relation to Patient _____ **Social Security #**__ __ __ -__ __-__ __ __ __ **D.O.B.** ____/____/_____

**Primary Insurance Company** _____

Member ID #_____ Group #_____

Name of Policyholder _____ Relation to Patient_____

Employer_____

**Secondary Insurance Company** _____

Member ID #_____ Group #_____

Name of Policyholder _____ Relation to Patient_____

Employer_____

## ASSIGNMENT AND RELEASE

AGREEMENT TO PAY: In consideration for the services rendered and to be rendered by The Allergy & Asthma Center, P.C. to the patient, I (we) agree to pay The Allergy & Asthma Center, P.C. for all services and charges as are ordered by the attending physician in accordance with the terms and policies of The Allergy & Asthma Center, P.C. If the services are not covered by private or government insurance, I (we) agree to pay The Allergy & Asthma Center, P.C. its standard non-discounted rate for the services provided. I (we) understand that The Allergy & Asthma Center, P.C. will make available to me (us) upon request a schedule of the standard charges for its services. I (We) further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made, to pay collection costs, including court costs, reasonable attorney fees and interest from the date of demand, if this account is placed for collection. Also, I (we) hereby acknowledge that The Allergy & Asthma Center, P.C. cannot assume responsibility for money, clothing, bridgework, dentures, eyeglasses, jewelry, credit cards, or any other personal items kept in my possession.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign to The Allergy & Asthma Center, P.C. and the attending physician(s), expenses or other surgical or treatment expenses and benefits which are due or to become due to me as a result of medical services to the patient listed below. I hereby authorize the payments to be paid directly to The Allergy & Asthma Center, P.C. for any services furnished by the physicians or certified physician assistants under their supervision. I understand that I am responsible to The Allergy & Asthma Center, P.C. for payments made directly to me and for any services or charges not covered by my insurance carrier or out-of-state workers compensation claim.

CONSENT TO TREATMENT: I hereby voluntarily consent to medical care to include diagnostic procedures and medical treatment judged necessary by my physician or his designee. I acknowledge that no guarantees have been made to me as a result of this treatment. In addition to all other consents given elsewhere in this document, I specifically consent to medical procedures and tests necessarily performed upon me to aid and assist in the diagnosis and treatment of my child. These tests may include tests for the presence or absence of alcohol or controlled substances.

RELEASE OF MEDICAL INFORMATION: I hereby authorize The Allergy & Asthma Center, P.C. and all physicians involved with my care to release information from my medical records as may be required to any person, corporation or agency which is legally responsible or which The Allergy & Asthma Center, P.C. has good cause to believe is legally responsible, for processing and/or paying all or any part of The Allergy & Asthma Center, P.C.'s charges and/or professional fees; and, to any entity which has contracted with any insurer to conduct utilization or performance review. I hereby authorize The Allergy & Asthma Center, P.C. or any physician involved with my care to release information to any physician or health care facility to which I may be transferred for further medical care.

_____ Date _____

Signature of Patient (or Parent/Guardian for minor)

_____ Date _____

Witness (Employee of the Allergy & Asthma Center