Birmingham Allergy and Asthma Specialists, PC

Today's Date: __ __ / __ __ / __ __ __ __ **Date of Visit:** __ __ / __ __ / __ __ __ __

Physician: _____**Dr. Carol Smith** _____ **Dr. Clara Chung** **(please check one)**

Referred by:_____

PATIENT INFORMATION

CLINIC ID # (for internal use)	PATIENT NAME: First Middle Last	SEX	DATE OF BIRTH __ __ / __ __ / __ __ __ __

PATIENT HOME ADDRESS (include city, state, zip)	PATIENT HOME PHONE	PATIENT CELL PHONE

E-MAIL ADDRESS	PATIENT'S SOC. SEC. # __ __ __ -__ __ - __ __ __ __	RELATIONSHIP STATUS [ ]Single [ ]Married [ ]Div. [ ]Wid. [ ]Other	ETHNIC ORIGIN (optional)

PATIENT EMPLOYER NAME & ADDRESS	PATIENT WORK TELEPHONE	OCCUPATION

IF PATIENT IS A CHILD, PLEASE COMPLETE THE FOLLOWING INFORMATION

NAME OF LEGAL GUARDIAN (Mother/Father)	HOME PHONE	CELL PHONE	WORK PHONE
NAME OF LEGAL GUARDIAN (Mother/Father)	HOME PHONE	CELL PHONE	WORK PHONE

RESPONSIBLE PARTY (Person who is financially responsible for the clinic bill)

RESPONSIBLE PARTY: First Middle Last	RESP. PARTY SOC. SEC. # __ __ __ - __ __ - __ __ __ __	RESP. PARTY DATE OF BIRTH __ __ / __ __ / __ __ __ __

RESPONSIBLE PARTY HOME ADDRESS (include city, state, zip)

RESPONSIBLE PARTY HOME TELEPHONE	RESPONSIBLE PARTY CELL PHONE	RESPONSIBLE PARTY WORK PHONE

RELATIONSHIP OF RESPONSIBLE PARTY to PATIENT(check only one)

[ ] Self	[ ] Stepmother	[ ] Spouse	[ ] Child-insured has no financial resp	[ ] Child
[ ] Mother	[ ] Stepfather	[ ] Life Partner	[ ] Ward of State	[ ] Employee
[ ] Father	[ ] Grandparent	[ ] Significant Other	[ ] Emancipated Minor Child	[ ] Other Relationship

RESPONSIBLE PARTY EMPLOYMENT

[ ] Employed [ ] Unemployed [ ] Retired [ ] Other

RESPONSIBLE PARTY EMPLOYER NAME	EMPLOYER TELEPHONE

RESPONSIBLE PARTY EMPLOYER ADDRESS (include city, state, zip)

EMERGENCY CONTACT (Please list someone not living at same address)

EMERGENCY CONTACT NAME (1)	RELATIONSHIP TO PATIENT	ADDRESS
HOME PHONE	CELL PHONE	WORK PHONE
EMERGENCY CONTACT NAME (2)	RELATIONSHIP TO PATIENT	ADDRESS
HOME PHONE	CELL PHONE	WORK PHONE

INSURANCE INFORMATION (Please provide your current insurance card(s) and/or referral information)

PRIMARY INSURANCE COMPANY	SUBSCRIBER NAME	SUBSCRIBER EMPLOYER

ID NUMBER	GROUP NUMBER	EFFECTIVE DATE __ __ / __ __ / __ __ __ __	END DATE __ __ / __ __ / __ __ __ __	SUBSCRIBER DATE OF BIRTH __ __ / __ __ / __ __ __ __

RELATIONSHIP OF RESPONSIBLE PARTY to PATIENT(check only one)

[ ] Self	[ ] Stepmother	[ ] Spouse	[ ] Child-insured has no financial resp	[ ] Child
[ ] Mother	[ ] Stepfather	[ ] Life Partner	[ ] Ward of State	[ ] Employee
[ ] Father	[ ] Grandparent	[ ] Significant Other	[ ] Emancipated Minor Child	[ ] Other Relationship

SECONDARY INSURANCE COMPANY	SUBSCRIBER NAME	SUBSCRIBER EMPLOYER

ID NUMBER	GROUP NUMBER	EFFECTIVE DATE __ __ / __ __ / __ __ __ __	END DATE __ __ / __ __ / __ __ __ __	SUBSCRIBER DATE OF BIRTH __ __ / __ __ / __ __ __ __

IF PATIENT IS TRANSFERRING CARE TO OUR OFFICE, NAME OF PREVIOUS PROVIDER/CLINIC:

HOW DID YOU LEARN ABOUT OUR PRACTICE

[ ] Newspaper/Ad: _____ [ ] Employer [ ] Clinic Brochure [ ] Insurance Company [ ] Website

[ ] Referring MD: _____ [ ] Other: _____ [ ] Yellow Pages

Friend: _____ Relative: _____

Authorization to Release Information
And to
Pay Benefits to Provider

Please Read and Sign Below

A photocopy of this authorization may be used in place of the original

I hereby authorize Birmingham Allergy and Asthma Specialist, PC to release any medical or patient information acquired in the course of my examination to the insurance carrier(s)/Center of Medicare and Medicaid Services and its agents needed to determine these benefits payable for related services. I also authorize release of my medical information related to my symptoms/treatment to other health care providers when my provider refers me to them for specialty services.

In addition, I also hereby authorize payment of authorized insurance/Medicare benefits be made directly to Birmingham Allergy and Asthma Specialist, PC for the medical/surgical benefits if any, otherwise payable to me for his/her services. I understand the clinic charges may exceed insurance company/Medicare payment, and if greater than such, I will be responsible for paying that additional allowable amount.

As specified, I understand that, at any time, I may revoke this authorization of the release of my medical records. If I revoke this authorization, however, there may be difficulties in obtaining insurance payment for my treatment. In any event, I will assume complete responsibility for payment of all charges.

I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to the appointment. I will be responsible for the unpaid balance due on any bills if this is not done.

I understand, whether I sign as an agent or as a patient, that whatever services are rendered, including allergy extract and injections, by Birmingham Allergy and Asthma Specialist, PC, to the patient, obligates me to assume financial responsibility, and I agree to pay upon request to Birmingham Allergy and Asthma Specialist, PC all charges for services incurred by the patient. If the account is referred to an attorney/collection agency for collection, I understand that I am responsible for attorney fees and collection expenses. I understand that all bills are payable upon presentation and that I, not the insurance company, am responsible for the payment of the services. This office will file and collect from insurance when insurance benefits are present. I hereby authorize Birmingham Allergy and Asthma Specialist, PC to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered.

If you have any questions regarding this notice or our health information policies, please contact:
Birmingham Allergy and Asthma Specialists, PC, Attn: Jan Gibson, 3125 Independence Drive, Suite 210, Birmingham, AL 35209 or call (205) 943-1197 for further information.

_____	_____
SIGNATURE	SIGNATURE OF PARENT/LEGAL GUARDIAN (If applicable)
_____	_____
PRINTED NAME	PRINTED NAME
_____	_____
DATE	DATE