

PATIENT INFORMATION

Today's Date _____

Thank you for choosing our office! To serve you properly, we need the following information.

PLEASE PRINT NEATLY. All information will be kept confidential.

Patient Name _____ **Date of Birth** _____ **M** ___ **F** ___

Responsible Party (if different than patient) _____

Relationship to Patient _____ Responsible Party's Date of Birth _____

Patient Mailing Address _____

City _____ State _____ Zip Code _____

Billing (Responsible Party's Address (if different from above)) _____

City _____ State _____ Zip Code _____

Home Phone _____ Is it okay to leave a detailed message? Yes ___ No ___

Mobile Phone _____ Is it okay to leave a detailed message? Yes ___ No ___

Is it ok for us to send you text messages regarding your appointments and/or prescriptions? Yes No

Email Address (Used for medication authorizations and the portal)

Would you like to register for the patient portal?

(Access to the patient's medical records, labs, refill requests, and a way to message the provider directly) Yes ___ No ___

Employer (Patient's/Parent/Guardian's) _____ Work Phone _____

Marital status: (circle one) Minor S M W D Patient's Social Security No. _____ - _____ - _____

Emergency Contact Person _____ Phone No. _____

Relationship to Patient (for Emergency Contact Person) _____

Primary Care Physician _____ Phone No. _____

Preferred Pharmacy _____ Phone No. _____

Patient's Race: _____ Patient's Ethnicity: (circle one) Hispanic or Non-Hispanic

Language Preference: _____

If the patient is under 18 years of age, please complete the following.

Father's Name (Male Guardian) _____ Lives with child? Yes ___ No ___

Mother's Name (Female Guardian) _____ Lives with child? Yes ___ No ___

INSURANCE INFORMATION

Insurance Co. _____ Group No. _____ ID No. _____

(Fill out the following information if the patient is not the cardholder)

Cardholder _____ Relationship _____

Birth Date _____ Social Security No. _____ (may be necessary to file insurance)

If you have additional insurance, please complete the following:

Insurance Co. _____ Group No. _____ ID No. _____

(Fill out the following information if the patient is not the cardholder)

Cardholder _____ Relationship _____

Birth Date _____ Social Security No. _____ (may be necessary to file insurance)

LIMITS OF CONFIDENTIALITY

By signing below, you are authorizing treatment and the release of medical information necessary to process your insurance claim. You are also authorizing the release of your medical information to referring doctors and/or insurance companies on behalf of Bayside Allergy, PC. If applicable this authorizes us to bill Medicare and release any information needed to determine payment for any specific date of service.

_____ **PLEASE CHECK HERE IF WE ARE AUTHORIZED TO SHARE MEDICAL INFORMATION WITH ANY IMMEDIATE FAMILY MEMBERS. IF SO, THEN PLEASE LIST NAMES OF PERSONS THAT ARE AUTHORIZED TO RECEIVE INFORMATION.**

NAME _____ RELATIONSHIP _____
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FINANCIAL POLICIES

1. It is our office policy for you to pay your co-payment at the time of service unless other arrangements have been made. It is your responsibility to know how much your co-pay is. Payment methods available are Cash, Check, MasterCard, Visa, or Discover.
2. We will bill all primary insurances for you; however, you will be responsible for all co- pays, deductibles, and any balance that your insurance does not cover.
3. It is your responsibility to make sure that you have any necessary referrals or authorizations that are required for your insurance from your primary care physician prior to being seen in our office. If you are not sure if a referral or authorization is needed, please check with your insurance before your appointment.
4. Please be sure that you have your current insurance card and identification with you at your visit. If we are not provided with a copy of these your insurance may not be billed until we have them.
5. It is your responsibility to know your insurance coverage prior to treatment (i.e.: allergy testing, office visits, allergy injections, allergy serum) as some insurance policies do not have allergy coverage.
6. Regardless of your insurance status, you are ultimately responsible for the balance of your account for all services rendered.

I have read and understand the above statements and have been offered the Notice of Privacy Practice in regard to my protected health information at Bayside Allergy, PC.

Patient/Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____