EISENSTADT ALLERGY & ASTHMA, LLP

Patient Registration

Date________________________________

PATIENT NAME____ DOB____________________
Last First MI

Address____
Street Apt # City State Zip Code

Social Sec. #______________________ Male____ Female____ Home Phone(______)__________________ S M W D
Marital Status (Circle)

Patient's Employer___________________________ Occupation______________________ Work Phone(_____)__________________

Responsible Party: Self_____ Other:____
Name Address

Family Physician and/or Clinic____
Name Address

Who referred you to our clinic? Friend_____ Family Member_____ Other____ Name______________________________________ Physician_____

Name/Address of Referring Physician____
Name Address Phone #

INSURANCE POLICYHOLDER'S INFORMATION (if different from patient)

Name_______________________________ Soc. Sec. #______________________ DOB__________ Relationship to Patient____________

Address____
Street Apt. # City State Zip Code

Home Phone #______________________ Work Phone #______________________ Employer Name______________________

Employer Address____

Primary Insurance____________________________________ **Second Insurance** ____________________________________

Group #____ Group #____

ID #____ ID #____

Policyholder Name/DOB______________________________ Policyholder Name/DOB______________________________

EMERGENCY CONTACT PERSON______________________________(______)______________(______)______________
Name Home Phone Work Phone

TO RESPECT YOUR PRIVACY, HOW MAY WE REACH YOU REGARDING YOUR HEALTH INFORMATION, TEST RESULTS, MEDICATION, BILLING, APPOINTMENTS?

Choose ALL that apply:

☐ 1) Leave message on voice mail: Home_____ Work_____ Cell#______________________________

☐ 2) Okay to leave message with:____
Name

☐ 3) Do not leave message on voice mail.

______________________________________ ______________________
Signature Date

I hereby request and authorize direct insurance payments to Eisenstadt Allergy & Asthma, LLP. I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of insurance. I also understand that if I have no insurance, I will be required to pay the cost of the services at the time I am seen. I understand that finance charges will accrue on any balance over 30 days. This form also authorizes the release of any medical information necessary to process this claim and to my referring physician and other providers involved in my care.

Date:__________________________ Signed:____

Medicare Authorization: I request that payment of authorized Medicare benefits be made to me or on my behalf to Eisenstadt Allergy & Asthma, LLP, for any services provided to me by that clinic. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Date:__________________________ Signed:____