ALLERGY & ASTHMA OF SOUTHERN IN, P.C.
PATIENT REGISTRATION

PATIENT INFORMATION:

Patient Name:____ Patient DOB:__________

Street Address:______________________City:______________State:________ZIP:________

SS Number:______________ Home Phone:_(____)______________ Cell Phone:_(____)______________

Place of Employment:________________________________Work Phone:_(____)______________

E-MAIL Address (Please PRINT clearly.):____

Emergency Contact Name:______________________________Relationship:______________________

Emergency Contact Home Phone #:_(___)__________Cell #_(___)__________Work #_(___)______________

Is it O.K. if we take a photograph of you to keep in your chart/send to your referring physician? YES_____ NO_____

MESSAGE INFORMATION:

Is it O.K. to leave an answering machine/voice mail message for you to:

Remind you of an appointment? YES_____ NO_____

Leave lab or nasal smear results: YES_____ NO_____

Tell you a medication has been refilled: YES_____ NO_____

If we call in a prescription for you, what pharmacy do you use?______________________City______________

If you are unavailable, is there anyone else with whom we can leave a message regarding:

Test results: YES_____ NO_____

Medication Refills: YES_____ NO_____

Appointments: YES_____ NO_____

Reply to medical questions: YES_____ NO_____

Discussion of financial issues: YES_____ NO_____

If the answer is "YES" to any of the above, whom do you authorize to take your messages? (This should be answered according to the relationship to the PATIENT.)

Spouse Name:__________________________Child Name:________________________________

Parent Name:__________________________Other (Please name)__________________________

INSURANCE INFORMATION:

Subscriber/Policyholder: Name:______________________________________DOB:________________

Relationship:____________________________Social Security #:________________

Address:____________________________________City:______________________

State:____________ ZIP:__________

Home Phone:_(____)______________ Cell Phone:_(____)______________

Place of Employment:____________________________WorkPhone:_(____)__________

BILLING INFORMATION FOR PATIENT UNDER 18 YEARS OF AGE:

Guarantor: Name:__________________________Relationship____________DOB____________

(Parent or Guardian Accompanying Patient)

Address:____________________________________City:______________________

State:____________ ZIP:__________ Social Security #____________________

Home Phone:_(______)______________ Cell Phone:_(______)______________

Place of Employment:____________________________WorkPhone:_(____)__________

Signature of Patient, Parent, or Legal Guardian:____

Rev.6/10 **Today's Date:** ________________________________