ASTHMA & ALLERGY SPECIALISTS

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DATE: ______________________

NAME: ____
Last First Middle Initial

ADDRESS: ____ CITY: ____________________

STATE: ____________ ZIP: __________ E-MAIL ADDRESS: ________________________

DATE OF BIRTH: ______________ SEX: ______ MARITAL STATUS: ________________

SS #: ____________ HOME PHONE: ________________ CELL PHONE: __________________
Area Code + number Area Code + number

WORK PHONE: ______________________ OCCUPATION: __________________________
Area Code + number

EMPLOYER'S NAME & ADDRESS: ____

FINANCIALLY RESPONSIBLE PARTY INFORMATION

RELATIONSHIP: (A) SPOUSE (B) PARENT (C) OTHER ______________________________

NAME: ____
Last First Middle Initial

ADDRESS: ____

CITY: ____________________ STATE: ____________ ZIP CODE: ____________

DATE OF BIRTH: ______________ SEX: ______ MARITAL STATUS: ____________

SOCIAL SECURITY #: ____

HOME PHONE/AREA CODE: ______________________ WORK PHONE: ______________

EMPLOYER'S NAME: ______________________ OCCUPATION: __________________

EMPLOYER'S ADDRESS: ____

DRIVER'S LICENSE # OF RESPONSIBLE PARTY: ____________________________

NAME OF PRIMARY PHYSICIAN: ____

HOW DID YOU FIND OUT ABOUT OUR OFFICE: (Circle Answer)

(a) Referred by a doctor (b) Another patient (c) Yellow pages

(d) Newsletter (e) Other (explain): ______________________

FORM 2

IN CASE OF EMERGENCY CONTACT ____
(Name) (Phone #)

INSURANCE INFORMATION

Insured Party: ______________________________ Relation to patient: ______________________________

Insured Party's Social Security #: ______________________________

Primary Insurance Company's Name: ______________________________

Mailing Address for Claims: ______________________________

____

Group #: ______________________________ Policy #: ______________________________

Secondary Insurance Company's Name: ______________________________

____

Group #: ______________________________ Policy #: ______________________________

♦♦♦

Payment is expected at Time of Service

How will you be paying: (a) Check (b) Credit Card (c) Cash

♦♦♦

MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made to Edward T. McLaughlin, M.D. or Juan C. Mas, M.D. or Asthma & Allergy Specialists, LLC, on my behalf for any service furnished to me by Asthma & Allergy Specialists.

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits for related services.

LIFETIME AUTHORIZATION:

DATE: ______________________________ SIGNATURE: ______________________________

ALL PATIENTS INCLUDING MEDICARE PATIENTS:

I authorize the release of any medical information to my insurance company necessary to process an insurance claim.

DATE: ______________________________ SIGNATURE: ______________________________

I hereby assign, transfer, and set over to Edward T. McLaughlin, M.D., Juan Mas, M.D., and Asthma & Allergy Specialist, LLC, all of my rights, title, and interest to my medical reimbursement under my insurance policy.
DATE: ______________________________ SIGNATURE: ______________________________