PLEASE PRINT

ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES OF CENTRAL FLORIDA

PATIENT REGISTRATION

TODAY'S DATE:__________________

PATIENT INFORMATION

Patient Name:____

Home Address:_______________________________________

_________________________ Zip:_______________

Billing Address: ☐ Same as above__________________

_________________________ Zip:_______________

Occupation or Student:_______________________________

Employer or School Name:____________________________

Work Phone:____________________ Ext._______________

Home Phone:___________________________Cell:____________

SSN:____

DOB:_________________________ AGE:___________________

Gender: ☐ Male ☐ Female

Ethnicity:_______________Language preferred:______________

Marital Status: ☐ Single ☐ Married ☐ Other

Driver's Lic. #:____________________Email:_________________

IF PATIENT IS A MINOR PLEASE COMPLETE THIS SECTION

Father's Name:___________________________________

Address:____
Write "Same" if same as patient

SSN:__________________________ DOB:_____________

Home Phone:______________________________________

Employer Name:___________________________________

Employer Phone:__________________________________

Marital Status: ☐ Single ☐ Married ☐ Other

Mother's Name:____

Address:____
Write "Same" if same as patient

SSN:__________________________ DOB:_____________

Home Phone:____________________________________

Employer Name:__________________________________

Employer Phone:_________________________________

Marital Status: ☐ Single ☐ Married ☐ Other

With whom does the child reside? ☐ Both Parents ☐ Mom ☐ Dad

INSURED PARTY and INSURANCE INFORMATION

PRIMARY

☐ HMO ☐ PPO ☐ Medicare ☐ Medicaid

Ins. Company Name:_____________________________

Claims Address:________________________________

_________________ Zip:_____________

Phone Number:__________________________________

ID#:___________________________ Group#:__________

Name of the Insured Party:__________________________

Insured's SSN:_________________ DOB:_____________

What is the patient's relationship to the Insured Party?

☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY

☐ HMO ☐ PPO ☐ Medicare ☐ Medicaid

Ins. Company Name:_____________________________

Claims Address:________________________________

_________________ Zip:_____________

Phone Number:__________________________________

ID#:___________________________ Group#:__________

Name of the Insured Party:__________________________

Insured's SSN:_________________ DOB:_____________

What is the patient's relationship to the Insured Party?

☐ Self ☐ Spouse ☐ Child ☐ Other

REFERRAL SOURCE

Whom may we thank for this referral?

- ☐ Physician Name: ______________________Phone:______________
- ☐ Friend or Family (Name): ____________________________________
- ☐ Internet Site: ____
- ☐ Insurance Provider Network
- ☐ Advertisement in ________________
- ☐ Other ________________

RELEASE OF INFORMATION and ASSIGNMENT OF BEBFITS

I authorize the release of any medical information necessary to process insurance claims and coordinate care with other physicians involved in my healthcare. I assign insurance payment directly to Allergy, Asthma & Immunology Associates of Central Florida. I agree to pay all applicable insurance co-pays at the time of service. I agree to provide AAIACF with my most current insurance information at all times and to pay all deductibles, coinsurance and any balance not covered by my insurance upon demand. I agree that copies of this form will be valid as the original.

PATIENT SIGNATURE (or Parent if patient is a Minor): ___________________________________DATE: ___________