Patient Information Sheet

(Please Print)

NAME: (FIRST/MIDDLE/LAST) DATE:_____/_____/_____

_____

DATE OF BIRTH:_____/____/_____ ☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

HOME ADDRESS:_____ CITY:_____

HOME PHONE:_____ STATE:_____

WORK:_____ ZIP:_____

CELL:_____

EMPLOYER:_____ BUS.#_____

SPOUSE'S NAME:_____

SPOUSE'S DATE OF BIRTH:____/_____/_____ EMPLOYER:_____

PRIMARY DOCTOR:_____ BUS. #_____

ADDRESS:_____ CITY:_____ ZIP:_____

REFERRED BY:_____

LIST CURRENT MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

_____

_____

PHARMACY NAME:_____ PHONE #_____

IF PATIENT IS A MINOR, PLEASE COMPLETE INFORMATION BELOW:

PARENT'S NAME:_____

PARENT'S DATE OF BIRTH:_____/_____/_____ PHONE # _____

HOME ADDRESS:_____ CITY:_____ ZIP:_____

(IF DIFFERENT FROM PATIENT)

PARENT'S EMPLOYER:_____ BUS.#_____

PARENT'S NAME:_____

PARENT'S DATE OF BIRTH:_____/_____/_____ PHONE #_____

HOME ADDRESS:_____ CITY:_____ ZIP:_____

(IF DIFFERENT FROM PATIENT)

PARENT'S EMPLOYER:_____ BUS.#_____

(PLEASE COMPLETE INSURANCE INFORMATION ON PAGE 2)

Patient Information Sheet

(Please Print)

PRIMARY INSURANCE:	**SUBSCRIBER:**
ID #:	**GROUP #:**
SECONDARY INSURANCE:	**SUBSCRIBER:**
ID #:	**GROUP #:**

Please read:

Please present your insurance cards, any forms (completed and signed), your referral if one is required by your insurance, and your co-payment, if applicable, at each office visit. Failure to provide insurance information may result in your visit having to be rescheduled until this information is received.

We understand that emergencies and other situations occasionally lead to missed appointments. However, we reserve the right to charge for missed appointments and for appointments cancelled with less than 48 hours advance notice.

Authorization:

I hereby authorize Tullyview Allergy, P.C. to furnish information to insurance companies regarding my treatment and I hereby assign to Tullyview Allergy, P.C. all payments for medical services rendered to my dependents or myself. I have read the Billing Policy of Tullyview Allergy, P.C. and I understand that I am responsible for any amounts not covered by insurance.

Signature: _____ Date: _____