Allergy & Asthma Center

2625 Box Canyon Drive
Las Vegas, NV 89128

Patient Information

Patient Name (Last) (First) (M.I.)		DOB:	SSN:
Home #	Cell #		Work #
Marital Status S M D W	Sex: M F		Age:
Address:			Appt #
City:	State:		Zip:
Referring Physician Phone#		Primary Physician Phone#	
Emergency Contact		Phone #	
Email Address:			

Guarantor Information

Guarantor Name: (Last) (First) (M.I.)			SSN:
Address (If different)			DOB:
Employer		Occupation	

Insurance Information (Please have receptionist copy your insurance cards)

Primary Insurance Co:			Phone #
Policy Holders Name:	DOB:		SSN:
Claims Address:	City:	State:	Zip:
Policy ID#	Group #		Effective Date:
Secondary Insurance Co:			Phone #
Policy Holders Name:	DOB:		SSN:
Claims Address:	City:	State:	Zip:
Policy ID#	Group #		Effective Date:

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to the doctor. A copy of the signature is as valid as the original.

_____ _____ _____

Patient Signature **Guarantor Signature** **Date**