ALLERGY ASSOCIATES OF WESTERN MICHIGAN, P.C.

PLEASE PRESENT YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE OR OTHER PICTURE ID AT REGISTRATION

PATIENT INFORMATION: MUST BE FILLED OUT COMPLETELY USING LEGAL NAME

Patient Name: Last First MI Nickname (if any)

\- \- M S W D

Date of Birth Sex Social Security Number Marital Status (Circle one)

Address: Street City State Zip Code

☐**Home Phone**________________ ☐**Cell Phone**___________________ ☐**Email Address**_______________________
(Please check preferred method of contact)

IF THE PATIENT IS A MINOR CHILD:

☐ Child lives at home with both parents ☐ Mother has physical custody

☐ Father has physical custody ☐ Joint physical custody

Other:____

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient's portion at the time of service.

EMPLOYMENT (circle one) FULL-TIME PART-TIME SELF-EMPLOYED RETIRED UNEMPLOYED STUDENT

Employer/School Work/Other Phone

RESPONSIBLE PARTY / GUARANTOR INFORMATION (if not the patient)

Guarantor Name: Last First MI

\- \-

Date of Birth Sex Social Security Number

Address: Street City State Zip Code

Home Phone Cell Phone Work/Other Phone Email Address

INSURANCE INFORMATION

PRIMARY INSURANCE Subscriber's Name Employer

\- \-

Date of Birth Social Security Number Relationship to Patient

Date Policy went into effect Contract Number Group Number

SECONDARY INSURANCE Subscriber's Name Employer

\- \-

Date of Birth Social Security Number Relationship to Patient

Date Policy went into effect Contract Number Group Number

PLEASE COMPLETE SECOND SIDE

PRIMARY CARE PROVIDER____

REFERRING DOCTOR ____

EMERGENCY CONTACT

Name Relationship to Patient

Emergency Contact Number (check one): □Home □Cell □Work/Other

I have been offered the Privacy Notice of Allergy Associates of Western Michigan, P.C., and attest to the above information.

Signed:______________________________________ Date:_______________

I authorize insurance payment directly to Allergy Associates of Western Michigan, P.C. I accept responsibility for any unpaid amounts where applicable. I understand that I am responsible for full payment if I have failed to obtain any required authorizations from my Primary Care Physician and/or have failed to provide current information. I further authorize the release of any medical records needed to process claims.

Print Patient Name:_____________________________ Date:_______________

Print Name of Responsible Party (if other than patient):___________________________

Relationship to patient:______________________________________

Patient/Responsible Party Signature:____________________________________

To whom may we give patient information?

Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number

How would you prefer to receive appointment reminders?

□ Email (please provide email address)_____________________________
□ Text (please provide cell phone number)___________________________
□ Phone (please provide phone number)_____________________________

Would you like to receive text reminders for scheduled injections? □ Yes □ No

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