

ALLERGY & ASTHMA CLINICS OF GEORGIA, P.C.

Patient Information

Patient (Legal Name) _____ SSN _____

Marital Status _____ Sex _____ Race _____ Birthdate _____

Address _____

City/State _____ Zip Code _____

Home Phone # _____ Alternate Phone # _____

School (if Student) _____ Grade _____ School Phone # _____

Employer _____ Work Phone # _____

Employer's Address _____

City/State _____ Zip Code _____

If Patient is a child, please complete the following:

Parent's Name _____ SSN _____

Marital Status _____ Sex _____ Birthdate _____

Parent's Address _____

City/State _____ Zip Code _____

Home Phone # _____ Alternate Phone # _____

Employer _____ Work Phone # _____

Employer's Address _____

City/State _____ Zip Code _____

Referred by _____

In Case of Emergency, Contact _____

Insurance Information

NOTE: Please list all insurances, which cover the patient, in the order in which they should be filed.

Person Insured - Primary Insurance _____

Insured's Address _____

City/State _____ Zip Code _____

Relationship to Patient _____ Work Phone # _____ Birthdate _____

Name of Employer _____

Name of Insurance Company _____

Insurance Company's Address _____

City/State _____ Zip Code _____

Insurance Group # _____ Employee Policy # (or SSN) _____

Person Insured - Secondary Insurance _____

Insured's Address _____

City/State _____ Zip Code _____

Relationship to Patient _____ Work Phone # _____ Birthdate _____

Name of Employer _____

Name of Insurance Company _____

Insurance Company's Address _____

City/State _____ Zip Code _____

Insurance Group # _____ Employee Policy # (or SSN) _____

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician.

Signature _____ Date _____