Allergy & Asthma CONSULTANTS

Breathe easier with rapid allergy and asthma relief

Creve Coeur
711 Old Ballas Road, Suite 100
Creve Coeur, MO 63141
Phone: 314-569-0510 - Fax: 314.569.1085

St. Peters
3701 N. St. Peters Parkway, Suite C-3
St. Peters, MO 63376
Phone: 314-569-0510 - Fax: 314.569.1085

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PATIENT INFORMATION FORM

Please read over this information carefully and fill out everything that applies. Please be sure to be as accurate as possible. Keeping all your information current is the best way to make sure that your insurance claims are files quickly and without complication. Thank you for your cooperation!

PATIENT INFORMATION

Patient's Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

DOB: _____ Sex: ☐ Male ☐ Female Social Security Number: _____

Email: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Family members who are patients here: _____

Primary Care Physician Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone Number: _____

If patient is a minor please complete this section

Mother's Name: _____ DOB: _____
Last First

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address*: _____

City: _____ State: _____ Zip: _____

** Fill out Address only if different than above*

Father's Name: _____ DOB: _____
Last First

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address*: _____

City: _____ State: _____ Zip: _____

** Fill out Address only if different than above*

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INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____ Group #: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Is this person a patient here: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Is this person a patient here: _____

RESPONSIBILITY PARTY INFORMATION

Name of Person Responsible for Account: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

CONSENT

I give Allergy and Asthma Consultants P.C. permission to disclose my medical information to:

Family members name: _____ Relation: _____

I hereby, assign payment of authorization medical benefits to include major medical benefits to which I am entitle; to be made on my behalf to Allergy and Asthma Consultants, P.C. for any services furnished me by that practitioner. I authorize release of medical information needed to determine these benefits payable to related services. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Allergy and Asthma Consultants, P.C. does not deny any benefits or services because of race, color, national origin, age, gender, disability, religious or political beliefs. If you feel that you have been discriminated against, you may file a Complaint of Discrimination with the Manager of this facility. You will not suffer any penalty because you file a complaint.

In addition, I agree to pay any additional charges related to the cost of collection (including but not limited to, collection agency fees, reasonable attorney fees and court costs), in the event that I would fail to pay my bill.

Date: _____ Signature: _____

Patient (over 18 years) or responsible party