ALLERGY & ASTHMA MEDICAL CARE CENTER

☐ 896 TARGEE STREET, STATEN ISLAND, NY 10304
☐ 159 CLINTON STREET, BROOKLYN NY 11201

Patient Demographics and Contact Info

Required information for Insurance Billing and Patient contact

Account#:_____

Patient Name: _____
LAST FIRST MIDDLE

Home Address: _____
STREET CITY STATE ZIP CODE

Date of Birth: _____/_____/_____ **Gender: (** M **/** F **)**

Fill in your own information Below. If Patient is a minor, Please Fill In Parental Information.

Parent name: _____ **Date of Birth:** _____/_____/_____ **Gender (M / F)**

Marital Status: (Single **/** Married **/** Divorced **)** **Employer:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Preferred Contact: (** Home **/** Work **/** Cell **)**

EMERGENCY Contact : _____
NAME PHONE NUMBER

If CHILD -> Other Parent: _____
NAME PHONE NUMBER

Person Responsible for Bill: O **Self or Parent / O Other (Please Complete Section Below)**

Responsible Person:
LAST FIRST MIDDLE

Date of Birth: _____/_____/_____ **Relation to Patient:** _____

Employer: _____ **Employer Health Insurance ? (Yes / No)**

Home Phone: **Work Phone:**

Primary Insurance Information

Insurance: _____

ID #:_____ **Group/Policy#:** _____

Name on Insurance Policy: _____

Secondary Insurance Infromation (If Applicable)

Insurance: _____

ID #:_____ **Group/Policy#:** _____

Name on Insurance Policy: _____

Assignment of Benefits: I hereby assign all my money to which I am entitled for medical or surgical expense relative to the service reported herein, but not to exceed my indebtedness to said office. It is understood that any money received over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am responsible for any and all charges not covered by my insurance company. I hereby authorize the undersigned doctors to release any information acquired in the course of my examination and treatment for billing and insurances claims.

Signed: _____ **Date:** _____