Allergy and Asthma Specialists of Frederick

Alpa Jani, MD

DATE: _____

PATIENT LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP CODE_____

HOME PHONE: _____ CELL PHONE: _____ Which preferred?_____

GENDER: ____ BIRTHDATE: ____/____/_____ EMAIL: _____

For **CHILD**: GUARDIAN NAME & CELL # _____ For **ADULT**: MARITAL STATUS ___

GUARDIAN NAME & CELL # _____ SOCIAL SEC. #: _____

EMERGENCY CONTACTNAME, RELATIONSHIP & PHONE: _____

PRIMARY INSURANCE==========**SECONDARY INSURANCE**==========

COMPANY: _____ COMPANY: _____

POLICYHOLDER NAME: _____ POLICYHOLDER NAME: _____

DOB: _____ SSN:____ - ___ - _____ DOB: _____ SSN:____ - ___ - _____

POLICY #: _____ REFERRAL REQUIRED? Y N POLICY #: _____

GROUP #: _____ COPAY AMOUNT: _____ GROUP #: _____ COPAY AMOUNT: ____

EMPLOYER NAME/PHONE: _____ EMPLOYER NAME/PHONE: _____

==========

PRIMARY PHYSICIAN: _____REFERRED BY:_____

PREFERRED PHARMACY: _____ PHONE: _____

DO YOU PREFER 90-DAY SUPPLY? Y N HAS A FAMILY MEMBER BEEN SEEN IN THIS OFFICE? Y N

====**GUARANTOR INFORMATION** (PERSON FINANCIALLY RESPONSIBLE FOR PAYMENT AFTER INSURANCE)====

NAME: _____ADDRESS:_____

====**WHO MAY THE DOCTOR SPEAK WITH ABOUT YOUR MEDICAL CARE?**==========

NAME: _____ RELATIONSHIP: _____ PHONE: _____

Can we leave a message on your or their phone with confidential information? Y N

I acknowledge that I reviewed the Notice of Privacy Practices (NOPP) for Allergy and Asthma Specialists of Frederick and was offered a copy from the office or via the website allergyasthmafrederick.org.

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to Allergy and Asthma Specialists of Frederick for services rendered. I authorize representatives of Allergy and Asthma Specialists of Frederick to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

SIGNATURE: _____