DATE:_____

The Asthma Center
ALLERGIC DISEASE ASSOCIATES, P.C.

Sec. Initials:

OFFICE: ☐ Center City Philadelphia ☐ Society Hill Philadelphia ☐ Northeast Philadelphia ☐ Bala Cynwyd, PA ☐ Langhorne, PA
☐ Mount Laurel, NJ ☐ Woodbury, NJ ☐ Hamilton, NJ ☐ Forked River, NJ

PATIENT NAME: (Last)_____ (First)_____ DOB:_____

Cell: _____ Home:_____ Work: _____

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone No.:_____

Email:_____

By providing my email address above, I am signing up to receive emails from The Asthma Center. Emails include office announcements & emergency closures, allergy shot hours, pollen counts, allergy & asthma news and health tips, and other marketing communications. Subscriptions can be managed online and unsubscribed at any time. No medical information and no protected health information (PHI) will be exchanged through this service.

Signature: _____

If address changed in the past year, please complete:

ADDRESS: (Street)_____

(City)_____ (State)_____ (Zip)_____

PRIMARY INSURANCE

Insurance Name_____

Guarantor*_____

List person or insured name responsible to ensure payment of all covered & non-covered services.

Guarantor DOB_____

ID # _____

Group # _____

Relationship to patient_____

Employer Name _____

Employer Phone # _____

SECONDARY INSURANCE

Insurance Name_____

Guarantor*_____

List person or insured name responsible to ensure payment of all covered & non-covered services.

Guarantor DOB_____

ID # _____

Group # _____

Relationship to patient_____

Employer Name _____

Employer Phone # _____

☐ **Insurance Has Changed Since Last Visit**

Medicare and Commercial Insurance Patients:
I authorize the release of any medical information necessary to process all claims and I authorize payment of medical benefits to **Allergic Disease Associates, PC** for services rendered. It is the policy of Allergic Disease Associates PC and the policy of my insurance company that all co-payments be collected at the time of the medical service. There may be a $10 billing charge for each co-payment not paid at the time of service. I have received a copy of the Allergic Disease Associates, P.C. Practice Policies.

Signature: _____