Allergy and Asthma Care of Brooklyn

PATIENT INFORMATION FORM

Please write legibly*

PATIENT'S NAME (LAST) _____(FIRST)_____
D.O.B _____ SOCIAL SECURITY # _____
HOME TEL _____CELL #_____ EMAIL _____
ADDRESS _____ APT #_____ CITY/STATE/ZIP_____
EMPLOYER NAME _____ADDRESS_____
CITY/STATE/ZIP _____ WORK TEL _____X___
REFERRING DOCTOR NAME _____ADDRESS_____
_____CITY/STATE/ZIP _____PHONE #_____
PATIENT'S PRIMARY CARE DOCTOR _____ADDRESS_____
_____ CITY/STATE/ZIP _____ PHONE #_____
NAME OF SPOUSE/PARENT/LEGAL GUARDIAN _____
EMPLOYER_____ADDRESS_____
CITY/STATE/ZIP _____ WORK TEL _____X ___

PRIMARY MEDICAL INSURANCE (INSURANCE EFFECTIVE DATE_____)
NAME OF INSURANCE COMPANY_____ PHONE #_____
PLAN TYPE _____ ID#_____ GROUP #_____
POLICY HOLDER NAME (LAST)_____ (FIRST)_____
POLICY HOLDER D.O.B _____ ADDRESS_____
CITY/STATE/ZIP_____RELATIONSHIP_____
POLICY HOLDER SS #_____ EMPLOYER _____

SECONDARY MEDICAL INSURANCE (EFFECTIVE DATE _____)
NAME OF INSURANCE COMPANY_____ PHONE #_____
PLAN TYPE _____ ID#_____ GROUP #_____
POLICY HOLDER NAME (LAST)_____ (FIRST)_____
POLICY HOLDER D.O.B _____ ADDRESS_____
CITY/STATE/ZIP_____RELATIONSHIP_____
POLICY HOLDER SS #_____EMPLOYER _____

I WILL BE PAYING BY [] CASH [] CHECK [] CREDIT CARD

PATIENT OR AUTHORIZED PERSON: By signing below, I authorize the release of any medical information or other information necessary to process my claim. I hereby authorize and request that payment of this claim for services rendered be made directly to Cascya Charlot, MD (Allergy and Asthma Care of Brooklyn). I understand that this bill may be submitted electronically (by computer) and give my permission to do so. If my insurance carrier should send me a check for today's visit, I will endorse Dr. Cascya Charlot (Allergy and Asthma Care of Brooklyn) and forward it promptly. **By signing below**, I also acknowledge that I have read the notice of privacy practice in its entirety and agree with this policy *(the privacy practice notice is located on the website homepage at www.brooklynallergyDR.com, a hard copy can also be provided by request in the office)*

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
SIGNED _____ Today's Date _____
IF MINOR, NAME OF RESPONSIBLE PARTY_____