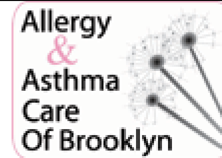
The Allergy and Asthma Care of Brooklyn 10 Plaza Street #1C Brooklyn, NY 11238 (347) 564 3211	

PATIENT INFORMATION FORM

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'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical information or other information necessary to process my claim.
Signed ________________________ Date __________________
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.
Date___________________ PATIENT'S SIGNATURE ________________________
IF MINOR, NAME OF RESPONSIBLE PARTY________________________________
SIGNATURE OF RESPONSIBLE PARTY ____________________________________