

**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](http://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 \_\_\_\_\_