ALLERGY & ASTHMA CENTER, P.C.

MICHAEL B. SHERMAN M.D., FAAAAI, FACAAI

PATIENT INFORMATION

PATIENT NAME (LAST _____ (FIRST) _____ (M.I.) _____

ADDRESS_____CITY_____STATE_____ZIP_____

DATE OF BIRTH_____/_____/_____AGE_____MARITAL STATUS_____ SEX: MALE_____ FEMALE_____

CELL NO: ( ) _____WORK NO: ( ) _____HOME NO: ( ) _____

EMAIL ADDRESS: _____SOCIAL SECURITY NO: _____

PHARMACY NAME: _____ADDRESS:_____PHONE NO: _____

MAIL AWAY PHARMACY NAME: _____

REFERING DOCTOR NAME: _____

_____
(STREET ADDRESS) (CITY/STATE/ZIP) (PHONE NO)

PRIMARY CARE DOCTOR NAME: _____

_____
(STREET ADDRESS) (CITY/STATE/ZIP) (PHONE NO)

MEDICAL INSURANCE INFORMATION

INSURANCE NAME: _____ID NO: _____

INSURANCE ADDRESS: _____

POLICY HOLDER NAME: _____POLICY HOLDER BIRTH DATE: _____

POLICY HOLDER SOCIAL SECURITY NO: _____PATIENT RELATIONSHIP: SELF☐ SPOUSE ☐ CHLD ☐

POLICY HOLDER ADDRESS: _____ POLICY HOLDER PHONE NO: _____

SECONDARY MEDICAL INSURANCE NAME: _____ID NO: _____

INSURANCE ADDRESS: _____

POLICY HOLDER NAME: _____POLICY HOLDER BIRTH DATE: _____

POLICY HOLDER SOCIAL SECURITY NO: _____PATIENT RELATIONSHIP: SELF☐ SPOUSE ☐ CHLD☐

POLICY HOLDER ADDRESS: _____POLICY HOLDER PHONE NO: _____

EMPLOYER INFORMATION

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____
(STREET ADDRESS) (CITY/STATE/ZIP) (PHONE NO)

NAME OF SPOUSE/PARENT/LEGAL GUARIDAN: (LAST) _____ (FIRST) _____ (M.I.) _____

SPOUSE/PARENT/LEGAL GUARDIAN EMPLOYER NAME: _____

SPOUSE/PARENT/LEGAL GUARDIAN EMPLOYER ADDRESS: _____

SPOUSE/PARENT/LEGAL GUARDIAN: CELL NO: ( ) _____WORK NO: ( ) _____

_____

IN CASE OF EMERGENCY- WHOM MAY WE CONTACT_____

CONTACT PHONE NO: ( ) _____RELATIONSHIP TO PATIENT_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Allergy & Asthma Center P.C.,** or insurance company to release any information required to process my claims.

PATIENT/PARENT/LEGALGUARDIAN SIGNATURE: _____**DATE:**_____