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WELCOME TO AUGUSTA ALLERGY & ASTHMA

Thank you for selecting our healthcare team!
Please fill out the entire form.
If you have any questions or need assistance, please ask-we will be glad to help.

PERSONAL INFORMATION

NAME _____ BIRTHDATE _____ SS# _____

ADDRESS _____ CITY/STATE/ZIP _____

PHONE# _____ (CIRCLE) MALE – FEMALE – SINGLE – MARRIED – DIVORCED – WIDOW

EMPLOYER _____ PHONE # _____ OCCUPATION _____

EMAIL _____ REFERRED TO US BY _____

I prefer to be contacted about appointment reminders and messages by: □ email □ text message □ phone

I authorize Augusta Allergy & Asthma to communicate with me through email, text messages or phone calls _____
Please initial

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR ACCOUNT _____ RELATIONSHIP _____

SS# _____ BIRTHDATE _____ DRIVERS LICENSE # _____

HOME PHONE _____ ADDRESS _____

CITY/STATE/ZIP _____ EMPLOYER _____

OCCUPATION _____ EMPLOYER PHONE _____

NAME AND ADDRESS OF NEAREST RELATIVE NOT LIVING WITH YOU

_____

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
NAME OF INSURED _____	NAME OF INSURED _____
RELATIONSHIP TO PATIENT _____	RELATIONSHIP TO PATIENT _____
POLICY #/ GROUP # _____	POLICY #/ GROUP # _____
INSURANCE ADDRESS _____	INSURANCE ADDRESS _____

I AUTHORIZE THE RELEASE OF ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYERS, UTILIZATION REVIEW, QUALITY ASSURANCE REVIEWER, REGULATORY AUTHORITIES, AND/OR OTHER HEALTH PRACTITIONERS

SIGNATURE _____ DATE _____

WE OFFER THE FOLLOWING METHODS OF PAYMENT: CASH, CHECK, CREDIT CARD