Allergy and Asthma Specialists of Frederick

Alpa Jani, MD

DATE: _____

PATIENT LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP CODE_____

HOME PHONE: _____ CELL PHONE: _____ BIRTHDATE: ____/____/_____

EMAIL: _____ GENDER: _____ PREFERRED PRONOUNS: _____

For **CHILD**: GUARDIAN NAME, CELL # _____ For **ADULT**:

GUARDIAN NAME, CELL # _____ MARITAL STATUS _____

EMERGENCY CONTACT NAME, RELATIONSHIP & PHONE: _____

PRIMARY INSURANCE========== **SECONDARY INSURANCE**==========

COMPANY: _____ COMPANY: _____

POLICYHOLDER NAME: _____ POLICYHOLDER NAME: _____

POLICYHOLDER DOB: _____ POLICYHOLDER DOB: _____

MEMBER ID #: _____ REFERRAL REQUIRED? Y N MEMBER ID #: _____

GROUP #: _____ COPAY AMOUNT $_____ GROUP #: _____ COPAY AMOUNT $____

EMPLOYER NAME: _____ EMPLOYER NAME: _____

==========

PRIMARY PHYSICIAN: _____REFERRED BY:_____

PREFERRED PHARMACY: _____ PHONE: _____

DO YOU PREFER 90-DAY SUPPLY? Y N HAS A FAMILY MEMBER BEEN SEEN IN THIS OFFICE? Y N

====**GUARANTOR INFORMATION** (PERSON FINANCIALLY RESPONSIBLE FOR PAYMENT AFTER INSURANCE)====

NAME: _____ADDRESS:_____

====**WHO MAY THE DOCTOR SPEAK WITH ABOUT YOUR MEDICAL CARE?**==========

NAME: _____ RELATIONSHIP: _____ PHONE: _____

Can we leave a message with you or the above person regarding confidential information? Y N

I acknowledge that I reviewed the Notice of Privacy Practices (NOPP) for Allergy and Asthma Specialists of Frederick and was offered a copy from the office or via the website allergyasthmafrederick.org.

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to Allergy and Asthma Specialists of Frederick for services rendered. I authorize representatives of Allergy and Asthma Specialists of Frederick to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

SIGNATURE: _____