

**PATIENT INFORMATION**

**(Please print)**

Mr.  Mrs.  Ms.  Jr.  Sr.  Other \_\_\_\_\_ Marital Status  Married  Single  Divorced  Widowed  Legally Separated  Other \_\_\_\_\_

Patient's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

**Mailing**

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Female  Male Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone numbers Home \_\_\_\_\_  Day  Evening Work \_\_\_\_\_  Day  Evening  
Cellular \_\_\_\_\_ Pager \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Employment Status  Employed  Full-Time Student  Part-Time Student  Retired  Self Employed  Unemployed

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Name of Pharmacy \_\_\_\_\_ City/Town \_\_\_\_\_ Phone Number \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION-if under age 18.**

Responsible Party Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Female  Male Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone Numbers Home \_\_\_\_\_ Work \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Street Address \_\_\_\_\_ City, \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employment Status  Employed  Full-Time Student  Part-Time Student  Retired  Self Employed  Unemployed

Employer \_\_\_\_\_ Employer phone number \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

**(provide your insurance card(s) to the front desk at check in)**

Insurance Company \_\_\_\_\_ Insurance Co. Phone Number (\_\_\_\_) \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ ID (policy number) \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_.  Male  Female Relationship to Patient \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_ Insurance Co. Phone Number (\_\_\_\_) \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ ID (policy number) \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_.  Male  Female Relationship to Patient \_\_\_\_\_

**Do we have permission to leave messages on your answering machine or with others who may answer your phone? (please circle) YES or NO**

I authorize Allergy Associates of New Hampshire to submit claims to my insurance carrier and to release any medical information necessary to process the claim. I also authorize payment of medical benefits to Allergy Associates of New Hampshire for any services for which they accept assignment. **I understand that I am responsible for payment of co-payments, coinsurance, deductible amounts and claims denied for lack of a referral.**

Signature \_\_\_\_\_ Date \_\_\_\_\_