Allergy Associates of NH Patient Registration Form

PATIENT INFORMATION **(Please Print)**

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Patient's Name (Last)_____ (First)_____ (MI)_____

Date of Birth ____/____/____ ☐ Female ☐ Male **Social Security Number** _____-_____- _____

Phone Numbers Home_____ Cell _____ Work_____

Preferred Number to Contact You ☐ Home ☐ Cell ☐ Work

Mailing Address_____ City, State, ZIP_____

Email _____ **May we send account information and statements via email?** ☐ Yes ☐ No

Physical Address (if different from mailing)_____

Primary Care Physician_____Address_____Phone number_____

Name of Pharmacy: _____City/Town_____Phone Number_____

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Island ☐ Black/African American ☐ White/Caucasian

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____Relationship_____

List the names of your child's Parents/Guardians below if patient is under 18 years old.

Name:_____Rel:_____ Name:_____Rel:_____

RESPONSIBLE PARTY INFORMATION (complete if patient is under age 18) ***Statements will be addressed to the Responsible Party***

Responsible Party Name (Last)_____ (First)_____ (MI)_____

Date of Birth ____/____/____ ☐ Female ☐ Male **Social Security Number** _____-_____-_____

Phone Numbers Home_____ Cell_____ Work_____

Address_____

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

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

PRIMARY INSURANCE INFORMATION **(provide your insurance card to the front desk at check-in)**

Name of Subscriber_____ **Patient Relationship to Subscriber**_____

Date of Birth_____/_____/_____ Social Security Number _____-_____-_____

Phone Numbers: Home_____ Cell _____ Work_____

Address:_____City/State/Zip:_____

Insurance Plan Name:_____ID#_____Group #_____

SECONDARY INSURANCE INFORMATION **(provide your insurance card to the front desk at check-in)**

Name of Subscriber_____ **Patient Relationship to Subscriber**_____

Date of Birth_____/_____/_____ Social Security Number _____-_____-_____

Phone Numbers Home_____ Cell _____ Work_____

Address:_____City/State/Zip:_____

Insurance Plan Name:_____ID#_____Group #_____

Do we have permission to leave messages on your answering machine or with others who may answer your phone? ☐ Yes ☐ No

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I authorize Allergy Associates of New Hampshire to submit claims to my insurance carrier and to release any medical information necessary to process claims. 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 that are denied for a lack of or valid referral.**

Patient (or Responsible Party) Signature_____ ***Date***_____

(Form must be signed)