Allergy & Asthma Clinic of San Antonio

Adult & Pediatric

www.allergyasthmasa.com

REGISTRATION FORM

Name: ____________________________ Age: _____ Date of Birth: ________________ Sex: ☐M ☐F

Home address: ____________________________ City: ________________ State: _____ Zip Code:_________

Mailing address: ____________________________ City: ________________ State: _____ Zip Code:_________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

E-mail:____ Social Security Number: ______- ____-______

Primary Language: ________________________ Race:________________ Ethnicity :_________________

Check all that apply: ☐Employed ☐Unemployed ☐Full-time student ☐Retired ☐ Other: ____________

Employer: ____________________________ Address: ____

Primary Insurance Information

Insurance: ___________________________ Policy Group #: ______________ Policy ID #: ______________

Address: ____________________________ City: ________________ State: _____ Zip Code:_________

Insured Name:____________________________ Date of Birth:_____________Social Security#:______- ____-______

Secondary Insurance Information

Insurance: ___________________________ Policy Group #: ______________ Policy ID #: ______________

Address: ____________________________ City: ________________ State: _____ Zip Code:_________

Insured Name:____________________________ Date of Birth:_____________Social Security#:______- ____-______

Person Responsible for the account (if anyone other than patient)

Name: ____________________________ Relationship to the patient:_____________________

Address: ____ Phone Number: ____________________

I, __________________________ , understand that my insurance, __________________________ has benefits for allergy and asthma coverage. As of today, __________________the benefits are the responsibility of the insurance and myself. The benefits as given to me are not guaranteed. They are just an estimate of coverage given to me at the time services are rendered. I understand that if any portions of these benefits are not covered by the insurance; it is my responsibility to pay the remaining balance. If my insurance policy is an HMO or a policy requires a referral from the primary physician, I understand that I am responsible to get the referral from the primary physician. The undersigned hereby authorizes the release of any information to all claims for benefits assignments and the release of any information relating to all claims for benefits submitted on my behalf or on behalf of my dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize my insurance to pay and hereby assign directed payment to Miguel J. Martinez Jr. M.D. PA, doing business as Allergy and Asthma Clinic of San Antonio. I understand that if I need letters or medical records for my personal use, I will be *charged a fee* according to the office policy. I understand that if I cancel my appointment with less than **24 hours in advance** or **no show** to my appointment or the appointment of my dependents be responsible for a *$50.00* fee.

____

Patient Name

____

Responsible Party

__________________ @__:_____ ☐AM ☐PM

Date and Time

____

Relationship

____

Witness

__________________ @__:_____ ☐AM ☐PM

Date and Time

2829 Babcock Road, Suite 115

San Antonio, Texas 78229

Phone: (210) 692-9555

Fax: (210) 692-9486

Form Revised: 07/2014