PATIENT INFORMATION PLEASE PRINT CLEARLY

Patient's Name: _____ Sex F M Age_____ Birth Date: _____ SS#:_____-____-_____

Physical Address: _____ _____
(Not a P.O. Box) City State Zip

Mailing Address: _____
City State Zip

Cell Phone: _____ Home Phone: _____ Work Phone: _____

E-Mail Address: _____ Marital Status _____ Drivers License: _____

Race: ☐ American Indian, Eskimo, Aleutian ☐ Asian, Hawaiian or Pacific Islander
☐Black or African American ☐White ☐Hispanic ☐Other ☐Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐Unknown **Primary Language**: _____

Employer_____ Work #: _____Address:_____
City State Zip

Spouse's Name: _____Employer:_____ Work _____ Address: _____
(Phone) City State Zip

Name of friend or relative at a different address: _____ Home Phone #: _____

Address_____ Work Phone #: _____
City State Zip

IF CHILD

Mothers Name: _____ Work # _____ Employer: _____
Driver's License #: _____ Address: _____
City State Zip

Fathers Name: _____ Work # _____ Employer: _____
Driver's License #: _____ Address: _____
City State Zip

INSURANCE INFORMATION

Responsible party: _____ Relationship: _____ Home Phone: _____

Address: _____ Work Phone: _____
City State Zip

Health Insurance through ☐Mother ☐Father Birth Date: _____ Medicare: _____

Health Insurance Company Name:_____

Address: _____
City State Zip

ID# or Cert#: _____ Group#: _____Policy #:_____

Is insurance through employment ☐YES ☐ No

Insured's Name: _____ Birth Date: _____

Other Health Insurance: _____

Insured's Name: _____ Birth Date: _____

Present Doctor: _____Address: _____ Phone:_____

Referred by: ☐ Physician ☐Friend ☐Google ☐Yellow Pages Other:_____

Referring person's name _____ Address: _____

List family members we have previously seen: _____

Please fill out HIPPA information on back

DISCLOSURE OF PATIENT PROCTECTED HEALTH INFORMATION

In general, the HIPPA privacy act gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provide the right to request confidential communications or that a communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home. I wish to be contacted in the following manner,

Check all that apply:

Telephone

Leave Detailed Message at home □Y □N
Ok to email appointment reminders □ Y □ N
Leave Detailed Message at work □Y □N
Leave Detailed Message on cell □Y □N
Ok to send text messages for appointment reminders □ Y □ N
Ok to send email for appointment reminders ____Y _____N

Choose one of the following:

Written Communication

Ok to mail to my home □Y □N
Ok to mail to mu work/office □Y □ N
Ok to fax to this Child number □Y □N
(___) _____

Check all that apply:

Authorized PHI Recipients

Spouse □Y □N
Parent □Y □N
Child □Y □N
Other (Relationship) □Y □N

_____

□ **No Restriction Requested**

I understand that if my insurance requires referrals, it is my responsibility to make sure a current one is on file. I also understand that I have a right to my medical records; and because of privacy regulations, my permission is needed to release them. Therefore, if insurance is filed through Central Texas Allergy Asthma, I authorize payment directly to Central Texas Allergy Asthma and release of any medical records necessary to process insurance claim that is filed.

_____ _____

Signature or Parent or Legal guardian Signature *Date*

Missed Appointment Policy

Failure to give 24 hour notice of cancellation of an appointment or n-showing an appointment will result in a charge of $25 on the patient's account. This charge cannot be billed to your insurance company. Failure to pay a no-show fee will be treated according to our policy on unpaid balances, with the exception of collection accounts.

Medical care will not be withheld for medical emergency. No showing (3) appointments can result in the patient being discharged from the practice, at the physicians discretion.

Emergency missed appointments will be taken into consideration

[ ] YES, I understand and acknowledge the Missed Appointment Policy

_____ _____

Signature **Date**