PATIENT DEMOGRAPHIC FORM **DATE:**_____

LAST NAME: _____FIRST NAME: _____ M.I.:_____

DATE OF BIRTH:_____AGE:_____ SOCIAL SECURITY NUMBER: _____GENDER:_____

MARITAL STATUS: _____

RACE (FOR LABORATORY PURPOSES): WHITE _____ BLACK OR AFRICAN _____ AMERICAN INDIAN OR ALASKAN NATIVE _____

ASIAN _____ HISPANIC _____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER _____

PREFERRED LANGUAGE: _____ENGLISH _____ OTHER (Please Specify):_____

HOME OR MAILING ADDRESS:

_____ APT#:_____CITY/STATE/ZIP:_____

CELL PHONE: _____ **HOME PHONE:** _____

EMAIL ADDRESS: _____

REFERRING PHYSICIAN/ADDRESS/PHONE: _____

PRIMARY CARE PHYSICIAN/ADDRESS/PHONE: _____

THE FOLLOWING IS REQUIRED IF PATIENT IS A MINOR PARENT(S) OR LEGAL GUARDIAN(S):

MOTHER NAME: _____ DOB: _____ FATHER NAME: _____ DOB: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP # _____

PRIMARY SUBSCRIBER DETAILS - RELATIONSHIP TO PATIENT: _____

LAST NAME: _____FIRST NAME: _____ DOB.:_____

SECONDARY INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP # _____

SECONDARY SUBSCRIBER DETAILS - RELATIONSHIP TO PATIENT: _____

LAST NAME: _____FIRST NAME: _____ DOB.:_____

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

FIRST NAME: _____ LAST NAME: _____ PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: _____

PLEASE READ AND SIGN:

I hereby authorize Roger H. Kobayashi, MD, James M. Tracy, DO, Brett V. Kettelhut, MD, & James L. Friedlander, MD, to furnish to the insurance company(s) information regarding me or my child's health and treatment. I also hereby assign to the doctor all payments for medical services provided to my dependents or me. I understand that to the extent allowable by law, that I am responsible for any amount whether or not covered by insurance program, Preferred Provider Organization (PPO), any Health Maintenance Organization (HMO), or any other provider of medical coverage.

PATIENT (SUBSCRIBER) SIGNATURE:_____DATE:_____

I request that payment of authorized MEDICARE payments be made to Allergy, Asthma & Immunology assoc., P.C., for any services furnished to me by Allergy, Asthma, & Immunology Assoc., P. C. I authorize the holder of medical information pertaining to me, to release to MEDICARE and its agents, information needed to determine these benefits or the benefits payable for related services.

MEDICARE AUTHORIZATION SIGNATURE:_____DATE:_____

In the event that my child/children should require medical care or treatment and my husband/wife and I should be unavailable or out of town, I give permission to Roger H. Kobayashi, MD, James M. Tracy, DO, Brett V. Kettelhut, MD & James L. Friedlander, MD, to care for my child/ren as these physicians deem necessary.

PARENT/LEGAL GUARDIAN SIGNATURE:_____DATE:_____

PLEASE PAY CO-PAY AT THE TIME OF EACH VISIT

IF YOUR INSURANCE PLAN REQUIRES A REFERRAL, YOU MUST HAVE THE REFERRAL BEFORE YOUR VISIT. (NEW & FOLLOW-UPS)

Allergy, Asthma & Immunology Associates, P.C.