SOUTHWEST ALLERGY AND ASTHMA CENTER, P.A.

ADULT & PEDIATRIC ALLERGY & ASTHMA
Bruce G. Martin, D.O.
Roberto Rodriguez, M.D.
Angelica Aguilar, FNP-BC

Patient Information

Date:_____ Referred By:_____

Last Name_____First_____Middle_____

Street Address_____City_____State_____

Zip Code_____Home#(____)_____Work#(____)_____Cell#(____)_____

Maiden Name(if applicable)_____Date of Birth_____Age_____

SS#_____DL#_____ Marital Status: ○ S ○ M ○ D ○ Other

Employer_____Occupation_____

Primary Language Spoken_____Race_____

Spouse/Parent/Guardian Name_____Date of Birth_____Age_____

SS#_____Work#(____)_____Cell#(____)_____

Employer_____Occupation_____

*****EMERGENCY CONTACT_____PHONE#(____)_____*****

*****Insurance Information*****

Name of Primary Insurance_____Co-Pay Amount_____

Policy ID #_____Group#_____

Policy Holder Last Name_____First_____Middle_____

Policyholder SS#_____Date of Birth_____

Relationship to patient_____Insured Employer_____

Insured Address(if different from patient's)_____

Name of Secondary Insurance_____Co-Pay Amount_____

Policy Holder Last Name_____First_____Middle_____

Policyholder SS#_____Date of Birth_____

Relationship to patient_____Insured Employer_____

Insured Address(if different from patient's)_____

*****Pharmacy Information*****

Pharmacy Name_____Pharmacy Phone(____)_____

Pharmacy Location (cross street)_____

PAYMENT POLICY:

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY BALANCE THAT ACCUMULATES AND AGREE TO PAY ANY BALANCE DUE AFTER INSURANCE HAS PAID OR RESPONDED.

AUTHORIZATION OF PAYMENT:

I HEREBY AUTHORIZE SOUTHWEST ALLERGY AND ASTHMA CENTER, P.A. TO RELEASE MEDICAL INFORMATION CONCERNING MY EXAMINATION AND/OR TREATMENT FOR INSURANCE PURPOSES AND TO RECEIVE DIRECT PAYMENT FOR MEDICAL BENEFITS PAYABLE TO ME FOR SERVICES RENDERED.

SIGNED_____DATE:_____