ALLERGY ASTHMA ASSOCIATES, PA • 333 Dr ML King Jr St N • St. Petersburg, FL 33701
Phone: 727-825-0111 • Fax: 727-825-0011

PATIENT INFORMATION:

Patient Name:_____Age:_____Birth Date:_____Sex: M F

Social Security#:_____Drivers License#:_____State:_____

Address (local):_____City:_____St._____Zip Code:_____

Home Phone:_____Cell Phone:_____

Employer:_____Occupation:_____Phone:_____

Address (out of area):_____City:_____St._____Zip Code:_____

Phone (out of area):_____Marital Status: ( ) Single ( ) Married ( ) Other

Spouse information: ( ) OR Emergency Contact ( ) (if not married, please give emergency contact name & phone information)

Name:_____Employer:_____

Occupation:_____Phone:_____

PRIMARY INSURANCE INFORMATION: Is this a Workers Compensation Insurance? ( ) YES ( ) NO

Insurance Co:_____Phone :_____

Mailing Address:_____

Name of Insured:_____Birth Date:_____Social Security#:_____

Policy #_____Group#_____Employer:_____

Insured's Relationship to Patient:_____

Secondary Insurance Information: Do you have other insurance coverage? ( )YES ( ) NO

Insurance Co:_____Phone :_____

Mailing Address:_____

Name of Insured:_____Birth Date:_____Relationship to Patient:_____

Policy #_____Group#_____Employer:_____

Other Misc. information:

Referred by: * Doctor ( ) *Family ( ) *Friend ( ) Phone Book ( ) Insurance Book ( ) Other ( )_____

*Please give name & address:_____

Family Physician (PCP)_____Phone:_____

Do you have other family members who are patients in our office?_____Relationship_____

FINANCIAL RESPONSIBILITY, ASSIGMENT OF BENEFITS, AND RELEASE OF PROTECTED HEALTH INFORMATION

- I herby agree to pay Allergy Asthma Associates, PA (AAA) for all charges (to include co-pays, deductible and co-insurance amounts) at the time of service. I understand that although the office may accept assignment of insurance benefits, the charges ultimately are my responsibility. I realize that if a balance is due necessitating the use of a collection agency, I agree to pay all collection costs, including attorney fees.
- I authorize AAA to file insurance claims on my behalf to the company (ies) with which I have coverage to include the Social Security Administration. I authorize payment to be made to AAA for services rendered to me.
- I consent to the release of protected health information which may be necessary to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.
- I acknowledge that I have received a copy of AAA Health Insurance Portability & Accountability Act (HIPAA) Notice of Privacy Practices.

Patient Signature:_____Date:_____