South Bay Allergy And Asthma Group, Inc.

Patient Name: _____
(First Name) (MI) (Last Name)

Date Of Birth: _____ Gender: _____ Marital Status: _____

SSN: _____

Address Details:

Contact Details:
Phone: _____ Alt #: _____
Email: _____

City: _____ State: _____
Zip: _____

Emergency Contact Details:
Contact: _____ Phone: _____
Relation: _____ Alt #: _____

Guardian Details (if patient is a minor):

Relation to Patient: _____
DOB: _____
(First Name) (MI) (Last Name)
Gender: _____
Contact Details: _____ Alt #: _____
Marital Status: _____

Insurance Details:

Check here if Self Pay: ☐

Primary Plan: _____
Plan Type: _____
Plan ID #: _____

Secondary Plan: _____
Plan Type: _____
Plan ID #: _____

Plan Subscriber Details:

Relation to Patient: _____
Primary Plan: _____
(First Name) (MI) (Last Name)
SSN: _____
DOB: _____ Gender: _____

Relation to Patient: _____
Secondary Plan: _____
(First Name) (MI) (Last Name)
SSN: _____
DOB: _____ Gender: _____

Authorization to Release Information:
I hereby authorize South Bay Allergy And Asthma Group, Inc. to release any information necessary to process insurance claims relating to the medical care rendered to myself or my child by South Bay Allergy And Asthma Group, Inc.

_____ _____
Signature of Patient or if minor, of Parent/Legal Guardian Date

Assignment of Medical Benefits:
I authorize payments of medical benefits to South Bay Allergy And Asthma Group, Inc. for any medical care rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by my insurance.

_____ _____
Signature of Patient or if minor, of Parent/Legal Guardian Date

By Initialing here, I have Received a copy of South Bay Allergy And Asthma Group, Inc. "Insurance Policy & Cost of Procedures". _____

Consent for Treatment of myself or a minor or dependent:
I consent and authorize routine and emergency medical treatment for me/my child/my dependent (circle one) when deemed necessary by authorized personnel including doctors at South Bay Allergy And Asthma Group, Inc. This authorization will remain effective unless revoked in writing by me.

_____ _____
Signature of Patient or if minor, of Parent/Legal Guardian Date