New Patient Registration Form

PATIENT INFORMATION

Full Legal Name (First)	(MI)	(Last)	(Nickname)

Street Address (No.) (Street Name)	(Apt. /Unit No.)	Date of Birth (M/D/YYYY)	Age	Sex

City	State	Zip Code	Social Security No.	Employer's Name

Home Phone	Mobile Phone	Work Phone (ext.)	E-mail Address

Check the corresponding box above indicating your preferred method of communication. Please note: e-mail communications require a separate consent.

Referring Doctor (Name & Address)	(Phone Number)
Primary Care Doctor (Name & Address)	**(Phone Number)**

Emergency Contact Person (Name)	(Phone Number)	(Relationship to Patient)

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (First)	(MI)	(Last)	(Phone Number)

Street Address (No.) (Street Name)	(Apt. /Unit No.)	Date of Birth	Age	Sex

City	State	Zip Code	Social Security No.	Patient's relation to the Responsible Party

Responsible Party's Employer (Name & Address)	(Phone Number)

INSURANCE INFORMATION

Primary Insurance Company (Name)	(Insured's/Subscriber's ID or Member No.)	(Insured's Group No.)

Primary Insurance Company (Claims Address)	(Phone Number)

Insured's Name (First)	(MI)	(Last)	Patient's relation to the Insured? ☐ Self ☐ Spouse ☐ Dependent

If the Insured/Subscriber is not the Patient or Responsible Party, then complete the requested information below:

Insured's (Street Address)	(Apt. /Unit No.)	Date of Birth	Age	Sex

City	State	Zip Code	Social Security No.	Insured's Occupation

Insured's Employer (Name & Address)	(Employer's Phone Number)

If the Patient is covered by a Secondary Insurance Policy, then complete the requested information below:

Secondary Insurance Company (Name)	(Insured's/Subscriber's ID or Member No.)	(Insured's Group No.)

Secondary Insurance Company (Claims Address)	(Phone Number)

Insured's Name (First)	(MI)	(Last)	Patient's relation to the Insured? ☐ Self ☐ Spouse ☐ Dependent

If the Insured/Subscriber is not the Patient or Responsible Party, then complete the requested information below:

Insured's (Street Address)	(Apt. /Unit No.)	Date of Birth	Age	Sex

City	State	Zip Code	Social Security No.	Insured's Occupation

Insured's Employer (Name & Address)	(Employer's Phone Number)

Lone Star Allergy & Asthma Center

Acknowledgement & Authorization

Receipt of "Notice of Privacy Practices"

I have received, read, and understand the "Notice of Privacy Practices" for Lone Star Allergy & Asthma Center. All questions that I have concerning the Notice have been answered to my satisfaction. I hereby authorize Lone Star Allergy & Asthma Center to use and disclose my **protected health information** or PHI in accordance with the said Notice. My requested restrictions to the use and disclosure of my PHI, if any, are as follows:	**Acknowledgement** (Initial This Box) ✘
I hereby authorize the following entities, if any, to receive my PHI until revoked by me in writing:	

NAME OF ENTITY	RELATIONSHIP

Receipt of "Medical Services Financial Agreement"

I have received, read, and understand the "Medical Services Financial Agreement" of Lone Star Allergy & Asthma Center. All questions that I have concerning the Financial Agreement have been answered to my satisfaction. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.	**Acknowledgement** ✘

Acknowledgement of Accuracy

I hereby state that all personal identifying and health insurance information that I have provided to Lone Star Allergy & Asthma Center is true and correct to the best of my knowledge. I also agree that it is my responsibility to notify Lone Star Allergy & Asthma Center if any of this information changes prior to receiving future healthcare services.	**Acknowledgement** ✘

Assignment of Benefits

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby assign, transfer, and set over payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.	**Acknowledgement** ✘

I have acknowledged the statements above regarding the ***Notice of Privacy Practices***, the ***Medical Services Financial Agreement***, the ***Accuracy*** of my personal information, and the ***Assignment*** of my insurance benefits to my physician by affixing my initials next to the said statements. All questions that I have concerning these statements or the documents referred to within have been answered to my satisfaction. I hereby state that I have read and understand the above statements and I have affixed my signature below attesting to the same.

______________________________/____________ ✘______________________________/______________

Printed Name of Patient / Date of Birth — Signature of Patient, Parent or Legal Guardian / Today's Date