Frederick Allergy and Asthma Center, LLC

Today's Date ________________ Patient Acct. No. ________________________

☐ New Patient ☐ Update Information Have you been here before ☐ Yes ☐ No When ________________

PATIENT INFORMATION Please Print Clearly	**GUARANTOR/SUBSCRIBER INFORMATION** ☐ Check if SAME as patient (complete only if different)
Name: Last First MI	Name: Last First MI
Address	Address
City, State, Zip	City, State, Zip
Home/Cell phone	Home/Cell phone
Work phone	Work phone
Email address	Relationship to you
Referred by	Subscriber Social Security #
Primary Physician	Subscriber Date of Birth
Social Security No.	Is this a worker compensation claim? ☐ Yes ☐ No
Sex ☐ M ☐ F Birth Date Age	Claim/File No.
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other	Insurance
Employer	Insurance Phone No.

PRIMARY INSURANCE (Please provide your card to our Staff)
If you have secondary coverage, you will be responsible for filing it directly to your carrier.

REFERENCES: How did you hear about us?

Friend: ☐

Radio: ☐

Newspaper: ☐

Employee: ☐

Physician: ☐ Name ______________________________

Convention/Fair/Seminar: ☐

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name	Relationship to you
Primary Phone No.	Secondary Phone No.

CONSENT TO TREAT, RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I acknowledge seeking medical care and consent to treatment. I request payment of insurance benefits (including Medicare benefits) be made to me or on my behalf to L. Brigida Hunter, MD to any services furnished me by that physician/physician group who accepts this assignment. I consent to using or disclosing my personal health information to carry out treatment, payment or health care operations to any holder of medical information about me including, but not limited to my insurance carrier (or in the care of Medicare, to the Center for Medicare and Medicaid Services (CMS) and its agencies) to determine benefits payable for related services. I permit a copy of this consent to be used in place of the original. Either I, or my insurance carrier may revoke this consent, at any time in writing. I accept responsibility for any balance due on services rendered.

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Signature of Patient (or Beneficiary if patient under 18 years of age) Date