WELCOME

Thank you for choosing Allergy & Asthma Center of Tuscaloosa! We will strive to provide you the best possible healthcare. To help us meet all of your healthcare needs, please complete this form in ink with the most complete information possible. If you have any questions or need assistance, please ask us -- we will be happy to assist.

1 Personal Information

Date____________________

Patient's Full Name____ Birthdate:_________________________

Name patient wishes to be called______________________________ Social Security # ___________________

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address____ City___________________ State______ Zip___________

Employer____ Occupation________________________

Referred By______________________________________ Email Address____________________________

2 Responsible Party

Please complete information for both parents if patient is a minor.

Name___________________________________ Relationship_______________ Home Phone________________

Birthdate_________________________ Soc. Sec.#_____________________ Driver's License#_______________

Address_______________________________________ City________________ State_____ Zip_________

Employer________________________________ Occupation________________ Work Phone__________Ext____

Name___________________________________ Relationship_______________ Home Phone________________

Birthdate_________________________ Soc. Sec.#_____________________ Driver's License#_______________

Address_______________________________________ City________________ State_____ Zip_________

Employer________________________________ Occupation________________ Work Phone__________Ext____

3 Additional Contact Information

Home Phone____________________________________ Cell Phone_______________________________

Work Phone____________________________________ Ext_________

Where do you prefer to receive calls? ☐ Home ☐ Cell ☐ Work

How do you prefer to be reminded of your appointments? ☐ Phone ☐ Text ☐ Email

In case of emergency, who should we contact? Name____

Relationship________________________ Home#________________ Cell#______________ Work#______________

4 Insurance Information

Primary Insurance

Insurance Company____ Employer____________________________

Policy Holder______________________________ Birthdate___________________ SSN_________________________

Contract Number____ Effective Date___________________

Group#___________________________ Deductible___________________

Relationship of patient to policyholder______________________________________

Secondary Insurance

Insurance Company____ Employer____________________________

Policy Holder______________________________ Birthdate___________________ SSN_________________________

Contract Number____ Effective Date___________________

Group#___________________________ Deductible___________________

Relationship of patient to policyholder______________________________________

5 Additional Information

Pharmacy

Name____ Phone Number_________________________

Address____ City_______________ State______ Zip___________

Primary Care Physician

Name____ Phone Number_________________________

Address____ City______________ State_____ Zip___________

Do we see other members of your family? If so, whom?____

Can we leave a message / lab results with a family member? ☐ Yes ☐ No

If yes, with whom? Name____________________________________ Relationship_________________

Can we leave a message / lab results on voicemail? ☐ Yes ☐ No

I consent to treatment necessary for the care of the above named patient. I authorize the release of medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittals of my medical records, if necessary.

Signature____

For your convenience, we offer the following methods of payment. **Payment is due in full at each appointment.**
Please check the option which you prefer:

☐ Cash ☐ Check ☐ Credit Card ☐ I wish to discuss the office policy.

Thank you for completing this form. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask -- we are always happy to help.