

Patient Registration Form  
Please Print

Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Patient \_\_\_\_\_  
Last Name First Initial

Responsible Party (If a minor) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Referred by \_\_\_\_\_ If student, name of school \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birth Date \_\_/\_\_/\_\_  Single  Married  Separated  Divorced  Widowed

Patient employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Who is responsible for this account? (*Who pays the bills?*)  Self  Other (name, address, relationship to patient)  
\_\_\_\_\_

Do you have medical insurance?  Yes  No Primary Insurance Company \_\_\_\_\_ Secondary \_\_\_\_\_

Policy Holder \_\_\_\_\_

Please Read and Sign the Following Office Policies

**Assignment of Insurance Benefits**

The undersigned hereby authorizes the release of information to referring physicians and any interested party for the purpose of medical claim processing. The undersigned also authorizes payment of medical benefits directly to Arizona Allergy & Asthma Specialist, P.C. and accepts financial responsibility for all charges incurred.

\_\_\_\_\_  
*Signature of Insured/Guardian* *Date*

**Insufficient Fund Policy**

I understand and agree that if a check is returned for insufficient funds, the office will only accept cash or credit card payment thereafter and I will be obligated to pay a returned check fee of \$30.00.

\_\_\_\_\_  
*Signature of Insured/Guardian* *Date*

**Cancellation Policy**

I understand and agree that I will give 24 hours notice if unable to make a scheduled appointment. A charge of \$30.00 will be assessed to my account for missed or broken appointments without 24 hrs notice.

\_\_\_\_\_  
*Signature of Insured/Guardian* *Date*