Arizona Allergy & Asthma Specialists
16611 South 40th Street, Suite 170
Phoenix, AZ 85048 480-705-8844
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)

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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.

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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.

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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 $50.00 will be assessed to my account for missed or broken appointments without 24 hrs notice.

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Signature of Insured/Guardian *Date*