Smith Allergy & Asthma SPECIALISTS

SMITH ALLERGY AND ASTHMA SPECIALISTS OF CENTRAL NEW YORK

PATIENT INFORMATION:

Patient Name _____ **Social Security #**_____

Address _____ City_____

State _____ Zip _____ Date of Birth _____ Sex (Circle) M F

Marital Status S M D W Home Phone (____)_____ Work Phone (____)_____

Cell Phone (____)_____ E-Mail Address_____

BEST WAY TO CONTACT YOU FOR APPOINTMENT REMINDERS: ___ E-mail ____ Cell _____ Home _____Text

Pharmacy used for prescriptions _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name _____ Relationship _____ Phone (____)_____

EMPLOYER:

Name _____ Address _____

WHO REFERRED YOU TO THIS OFFICE?

Referring Physician Name _____ Friend Name _____

____ Patient _____ HMO or Health Insurance Co. _____ Website ____ Radio ____ Paper _____ TV

INSURANCE INFORMATION:

	PRIMARY INSURANCE	**SECONDARY INSURANCE**
Insurance Company	_____	_____
Policy Holder Name	_____	_____
Insured's Birth Date, SS#	_____	_____
Relationship to Patient	_____	_____
Policy #, Group #	_____	_____

I have received a copy of the Smith Allergy & Asthma Specialists of CNY Notice of Privacy Practices (HIPAA). I authorize the release of medical information necessary to communicate with referring physicians and to process insurance claims. I authorize direct payment of covered benefits to the provider. The patient is responsible for all fees, regardless of insurance coverage. Co-payments are due at time of service.

Date _____ Patient Signature _____