Print Form

Allergy and Asthma Center of Austin

Acct:_____

PATIENT DEMOGRAPHIC SHEET

Patient Last Name	Patient First Name	Marital Status	Date of Birth	Age	Sex	Social Security Number
			/ /			- -

Street Address	City and State	Zip Code	Home Phone Number
	,		( ) -

Driver's License Number	Email Address	Cell Phone Number
		( ) -

Patient's Employer *or School Name (if student)*	Occupation	Work Phone Number Ext.
		( ) -

Employer's Street Address	City and State	Zip Code
	,	

Responsible Party/Relationship to Patient	Date of Birth	Social Sec. #	Home Phone Number
	/ /	- -	( ) -

Responsible Party's Employer	Responsible Party's Driver's License Number	Cell Phone Number
		( ) -

Responsible Party's Employer's Address	Email Address	Work Phone Number Ext.
		( ) -

Emergency Contact	Street Address	Home Phone Number
		( ) -

Relationship to Patient	Cell Phone Number	Work Phone Number Ext.
	( ) -	( ) -

Who referred you to our practice?

Name of Referring Doctor	Family/Primary Care Physician

Address	Address

Phone#	Phone#
( ) -	( ) -

List Family Members who are patients in our office:

INSURANCE INFORMATION

Primary Insurance	Effective Date	Name of Pol Hldr	Date of Birth	ID# / Group
	/ /		/ /	/

Insurance Phone number(s): ( ) -	SSN#: - -

Secondary Insurance	Effective Date	Name of Pol Hldr	Date of Birth	ID# / Group
	/ /		/ /	/

Insurance Phone number(s): ( ) -	SSN#: - -

Pharmacy Name	Address	Phone Number	Pharmacy Fax #
		( ) -	( ) -

Consent

I GIVE MY CONSENT FOR AACA TO DISCUSS PATIENT'S MEDICAL CARE AND PAYMENT FOR MEDICAL CARE WITH THE FOLLOWING PEOPLE:

Name/Relationship/Phone Number	Name/Relationship/Phone Number	Name/Relationship/Phone Number

PATIENTS READ AND SIGN AGREEMENT

1- I hereby give my consent for physicians of **Allergy and Asthma Center of Austin** to evaluate and treat the above named patient.
2- I have been provided with the **Privacy Practices Notice** of Allergy and Asthma Center of Austin.
3- I understand that my personal health information will be used for the purpose of treatment, payment and the coordination of health care needs of the patient.
4- I have also been provided and agree with the **Financial Policy** of Allergy and Asthma Center of Austin.

Signature of Patient or Guardian:_____ **DATE:**_____