ALLERGY & ASTHMA CENTER OF AUSTIN

William C Howland, III MD
Allen K Lieberman, MD
512.345.7635
www.nosneezes.com

PATIENT DEMOGRAPHIC FORM **ACCT #** **DATE**

PATIENT INFORMATION

Last Name	First Name		Initial	Nickname
Date of Birth	Social Security Number		Gender ☐ Male	☐ Female
Marital Status ☐ Married ☐ Single	☐ Domestic Partner	☐ Separated	☐ Widowed	☐ Other
Home Address	Apt. #	City	State	Zip Code
Home Phone	Work Phone		Cell Phone	
Employer		Employer Phone		
Email Address	Occupation:			

IF PATIENT IS A MINOR CHILD, PLEASE COMPLETE THIS SECTION

Mother's Name ☐ Custodial Parent		Father's Name	☐ Custodial Parent
Mother's Home & Cell Phone Numbers		Father's Home and Cell Phone Numbers	
Mother's Employer/Phone Number-Ext		Father's Employer/Phone Number-Ext	

RESPONSIBLE PARTY/INSURANCE INFORMATION

Relationship to Patient ☐ Self (if self. Skip to Emergency/Next of Kin)			☐ Spouse ☐ Parent	☐ Other
Last Name	First Name		Initial	
Date of Birth	Social Security Number		Gender ☐ Male	☐ Female
Home Address	Apt. #	City	State	Zip Code
Home Phone	Work Phone		Cell Phone	
Employer		Employer Phone		
Insurance Company/Phone Number		Identification Number	Group Number	
Subscriber/Policy Holder	Subscriber/Policy Holder's Date of Birth		Relationship to Patient	

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

Last Name	First Name		Relationship to Patient	
Home Address	Apt. #	City	State	Zip Code
Home Phone	Work Phone		Cell Phone	

PHYSICIAN/REFERRAL INFORMATION

Who may we thank for your referral?	
Primary Care Physician/Phone Number	Referring Physician/Phone Number

**FAMILY MEMBERS **

Please list Family Members who are patients in our office:

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William C Howland, III MD **Allen K Lieberman, MD**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FINANCIAL AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I have received Allergy & Asthma Center of Austin's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I authorize Allergy & Asthma Center of Austin to release any information in the course of my examination or treatment to my insurance company. I further authorize any benefits due for services rendered to be paid directly to William C Howland III, MD, Allen K Lieberman MD and/or Allergy & Asthma Center of Austin.

I Hereby agree to pay any charges, deductibles and/or co-payments not paid for by my insurance plan that are deemed to be my responsibility for services rendered by the physicians and/or staff at the Allergy & Asthma Center of Austin. Furthermore, I agree to pay my portion at the time services are provided. I understand I am responsible for obtaining and providing all referral authorizations to the Allergy & Asthma Center of Austin in accordance with my insurance plan provisions. I authorize Allergy & Asthma Center of Austin to submit claims on my behalf. I agree to notify Allergy & Asthma Center of Austin immediately of any change in the status of my insurance plan, benefits or primary care physician. I understand failure to do so could result in non-payment by my insurance company and I would then be responsible for ALL unpaid charges.

Allergy & Asthma Center of Austin requires a 24-hour notice for appointment cancellations. I understand after the first failure to keep an appointment, I may be subject to a $25.00 charge for any following missed appointments without proper notification.

PATIENT/PARENT/GUARANTOR SIGNATURE **DATE**

PRINTED NAME OF PATIENT **RELATIONSHIP TO PATIENT**