

ALLERGY, ASTHMA, & RESPIRATORY CARE MEDICAL CENTER

PATIENT INFORMATION RECORD

PLEASE PRINT AND COMPLETE ALL SECTIONS BELOW

IS YOUR CONDITION WORK RELATED? YES NO

REFERRED BY: _____

PATIENT

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____
DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____ **DRIVER'S LICENSE #:** _____
GENDER: MALE FEMALE **MARITAL STATUS:** SINGLE MARRIED DIVORCED WIDOWED
ADDRESS: _____ **APT #:** _____ **CITY:** _____ **ST:** _____ **ZIP:** _____
HOME #: _____ **WORK #:** _____ **CELL #:** _____
EMAIL: _____ **EMPLOYER/SCHOOL:** _____

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

MOTHER'S NAME: _____ **DOB:** _____ **SS#:** _____
ADDRESS: _____ **APT #:** _____ **CITY:** _____ **ST:** _____ **ZIP:** _____
HOME #: _____ **WORK #:** _____ **CELL #:** _____
FATHER'S NAME: _____ **DOB:** _____ **SS#:** _____
ADDRESS: _____ **APT #:** _____ **CITY:** _____ **ST:** _____ **ZIP:** _____
HOME #: _____ **WORK #:** _____ **CELL #:** _____

INSURANCE

PRIMARY INSURANCE: _____ **ID#:** _____
SUBSCRIBER NAME: _____ **DOB:** _____
RELATION TO PATIENT: _____ **SS#:** _____
SECONDARY INSURANCE _____ **ID#:** _____
SUBSCRIBER NAME: _____ **DOB:** _____
RELATION TO PATIENT: _____ **SS#:** _____

EMERGENCY CONTACT

NAME: _____ **RELATIONSHIP:** _____
ADDRESS: _____ **APT #:** _____ **CITY:** _____ **ST:** _____ **ZIP:** _____
HOME #: _____ **WORK #:** _____ **CELL #:** _____

ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, AUTHORIZATION FOR TREATMENT, ACKNOWLEDGEMENT

- I HEREBY GIVE MY AUTHORIZATION FOR THE ASSIGNMENT AND PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO AARCMC GROUP IN BEHALF OF THE GROUP'S PHYSICIANS RENDERING SERVICES. I UNDERSTAND THAT MY INSURANCE PLAN MAY NOT PAY FOR ALL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RECEIVED WHETHER OR NOT THEY ARE COVERED BY THE INSURANCE. IN THE EVENT OF DEFAULT, I AGREE THAT A PHOTOCOPY OF THE AGREEMENT IS AS VALID AS THE ORIGINAL DOCUMENT.
- IF ACTING AS A GUARANTOR FOR A PATIENT OTHER THAN MYSELF, I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR AUTHORIZING AND GUARANTEEING PAYMENT FOR SERVICES RENDERED TO THE PATIENT.
- BY PROVIDING MY INSURANCE INFORMATION; I AFFIRM THAT I AM CURRENTLY AN ELIGIBLE MEMBER OF THE PLAN NAMED IN THIS INFORMATION RECORD.
- I AUTHORIZE TREATMENT FOR MYSELF AS THE PATIENT OR TREATMENT OF THE PERSON NAMED IF MINOR ABOVE BY A LICENSED AARCMC GROUP PHYSICIAN OR WHOM THE PHYSICIAN MAY DESIGNATE AS THE SERVICE PROVIDER.
- IF I ELECT TO PARTICIPATE IN CLINICAL TRIALS, I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION FOR PURPOSES OF CONTACT AND STUDIES BY AARCMC GROUP AND ITS CLINICAL TRIALS AFFILIATES.

CLINICAL TRIALS: I MAY BE CONTACTED FOR CLINICAL TRIALS FOR WHICH I MAY BE QUALIFIED: YES NO

SIGNATURE: _____ **DATE:** _____