# Florida Allergy & Asthma Associates

**Patient Information & Authorization Form** Date of Appointment _____/_____/ 20_____

**Patient's Name:** Mr Mrs Miss _____
Last First (Nickname) M.I

Home Phone: _____ Cell #: _____ Birthdate: _____/_____/_____ Age: _____ Male / Female

Primary Address: _____
Street & number City State Zip

Pharmacy Name & Address: _____ Pharmacy Phone:_____

E-mail Address: _____
(email addresses will not be sold or shared with a third party)

Patient's Occupation: _____ Employer: _____ Work #: _____

Patient's Social Security #: _____/_____/_____ Marital Status: M S D W

**Person to contact in case of emergency:** _____ Relationship: _____

Home phone: _____ Work phone: _____ ext _____ Cell #: _____

**IF MINOR; PARENT/GUARDIAN INFORMATION:**

**Mother:** _____ Home #: _____Cell #: _____

Address: _____City/State: _____ Zip: _____

**Father:** _____ Home #: _____Cell #: _____

Address: _____ City/State: _____ Zip: _____

**Guardian/Relationship:** _____ Home # _____ Cell # _____

Address: _____ City/State: _____ Zip: _____

Social Security # _____ DOB _____ Work Phone # _____

**PERSON RESPONSIBLE FOR BILL:** (insurance company does not apply) **Self** **Parent(s)** **Other**

Name: _____ Relationship: _____DOB:_____

Billing Address: _____

Social Security #: _____ Home Phone: _____ Work Phone:_____

**MEDICAL INSURANCE INFORMATION:**

Name of insurance:_____ Policy #:_____ Group #:_____

Insurance Co. Phone: _____ Employer: _____ Employer's phone: _____

Insured's name: _____ Date of Birth: _____ Home #_____

Primary care / Family doctor: _____ Referred by: _____

**For all Patients:**

I hereby authorize Florida Allergy and Asthma Associates (FAAA) to furnish my insurance company or any representative thereof with any and all information which may be requested regarding my past or present physical condition and treatment. I hereby authorize FAAA to administer such medical care as may be deemed advisable in the diagnosis and treatment. I further authorize my insurance company or other parties to pay direct to FAAA, my medical expenses payable under the terms of my contract. In making this assignment I also agree that any balance not covered will be paid by me and that photocopies of this form will be valid. Should your account have to go to collections, you will be charged a fee of 30% of total charges.

_____ _____

Signature Date

**For all Medicare Patients:**

**PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its Intermediaries or Carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the Physician or Organization furnishing the services or authorize such physician or Organization to submit a claim to Medicare for payment to me.

_____ _____

Signature Date