ASTHMA & ALLERGY CLINIC OF MARIN & SF INC.

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PATIENT REGISTRATION

Today's Date _____ Language Speaking_____

PATIENT INFORMATION (Please Print) I.D. Verified [ ]

Patient's Name_____ Sex M__ F__
Last First MI

Parent/Legal Guardian Name(if patient is a minor)_____ Relationship_____

Patient Date of Birth_____ Age_____ Marital Status S / M / W / D / S

Address _____
Street City State Zip

Home Phone #( )_____ Cell Phone # ( ) _____
Work Phone # ( ) _____

Employer or School _____ Occupation _____

Emergency Contact Person Name _____ Relationship_____

Address(if different)_____ Phone # ( )_____

Pharmacy Name _____ Address_____

Primary Care Physician _____ Phone # ( )_____

Referral Physician (if any)_____ Phone # ( )_____
How did you learn of our practice? [ ]Online [ ]Friend/Relative [ ]Primary Doctor

INSURANCE INFORMATION

Do you have medical insurance? [ ]No [ ]Yes If Yes, please complete the following:
PRIMARY INSURANCE _____ Effective Date _____
Patient Relationship to Insured [ ] Self [ ]Spouse [ ]Child [ ] Other _____
Policy Holder Name(If other then self) _____ Date of Birth _____ Policy Holder's Address(if different from patient)_____

SECONDARY INSURANCE(if any)_____ Policy Holder Name_____ DOB_____

ASSIGNMENT AND RELEASE

I authorize the release of any medical information necessary to process the insurance claim and authorize payment of medical benefit to Asthma & Allergy Clinic of Marin & S.F., Inc. or supplier for service described in the insurance claim form. I acknowledge that co-payments are due at the time of services. I will personally responsible for payment for charges that are not benefit of , not authorized by my ins., not considered medical necessity by my insurance or any late payment fee/ interest.
FOR MINOR: I authorize provision of medical care for above named patient by physicians at AACM. I hereby assume full financial responsibility for payment for medical services by the above named patient in accordance with terns as set forth in the authorizations above.
OFFICE POLICY: For missed appointments or appointments cancelled with less than 48 hr notice, there is $50 fee for new patients and $35 for returning patients.

_____ _____
Patient/Parent/Legal Guardian Signature Date

AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

Do we have your permission to: **(Must Complete)**
Leave a detailed message regarding your medical information and /or account on your
Home answering machine: [ ] Yes [ ] No Cell: [ ] Yes [ ] No Work: [ ] Yes [ ] No
Discuss your medical condition with someone other than your physician (i.e. family members). [ ] Yes [ ] No
OR, discuss your child's medical condition with someone other than his/her physician, parents or guardian.[ ] Yes [ ] No
If yes, Name of individual _____ Relationship _____
Name of individual _____ Relationship _____

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of April 14, 2003.

_____ _____
Patient/Parent/Legal Guardian Signature Date

" NOTICE TO CONSUMERS: Medical doctors are licensed & regulated by the Medical Board of CA (800)633-2322, www.mbc.ca.gov."