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PATIENT REGISTRATION

Account #: _____ Today's Date: _____

Patient's Name: _____ DOB: _____ Sex: _____

Mailing Address: _____

City/State: _____ Zip code _____ SS#: _____

Email: _____ Phone#: _____

Occupation: _____ Work Phone#: _____

Responsible Party: _____ DOB: _____ Relationship: _____

Mailing Address: _____

City/State: _____ Zip code _____ SS#: _____

Email: _____ Phone#: _____

Occupation: _____ Work Phone#: _____

Primary Insurance: _____ Secondary Insurance: _____

Ins. Address: _____ Ins. Address: _____

Insured's Name: _____ Insured's Name: _____

Insured's DOB: _____ Insured's DOB: _____

ID#: _____ ID#: _____

Group#: _____ Group#: _____

Employer: _____ Employer: _____

Effective Date: _____ Effective Date: _____

Emergency Contact: _____ Relationship: _____

Primary Phone: _____ Secondary Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Columbia Asthma & Allergy Clinic or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date: _____



REFERRING PHYSICIAN INFORMATION FORM

Were you referred to CAAC by another provider? Yes No

Referring Provider/Clinic: _____

Provider Address: _____

Physician Phone: _____ Physician Fax: _____

Type of Physician: _____

As a courtesy to other providers working on your medical team and to assist with continuity of care, CAAC is happy to send a copy of your medical records to any physician you specify. Please list them below:

Primary Care Provider/Clinic: _____

Provider Address: _____

Physician Phone: _____ Physician Fax: _____

Type of Physician: _____

Provider/Clinic: _____

Provider Address: _____

Physician Phone: _____ Physician Fax: _____

Type of Physician: _____

By signing this document, I authorize CAAC and its providers to release my medical records to the above named physicians. I may revoke this authorization at any time in writing.

Patient/Guardian Signature _____ Date: _____