Allergy and Asthma of Illinois, SC

Stephen J. Smart, MD
Penelope A. Ewbank, MD

Date______________________

PATIENT INFORMATION QUESTIONNAIRE

Last Name______________________________ First Name______________________________ Middle Initial__________

Address_________________________________ City____________________ State_________Zip Code___________

Gender ☐ Male ☐ Female ☐ Married ☐ Single Home Phone Number:__________/_______________

Date of birth ________/______/______ Work Phone Number__________/_______________

Social Security Number________/__________/________ Cell Phone Number__________/_______________

Employer______________________________________

Address of Employer____

City__________________________________State_________Zip Code____________

Family Doctor____________________________ Address of Family Doctor______________________________________

CUSTODIAL PARENT / GUARDIAN (if patient is a minor)

Last Name______________________________ First Name______________________________ Middle Initial__________

Address_________________________________ City____________________ State_________Zip Code___________

Gender ☐ Male ☐ Female ☐ Married ☐ Single Home Phone Number:__________/_______________

Date of birth _____/__________/______ Work Phone Number__________/_______________

Social Security Number________/__________/________ Cell Phone Number__________/_______________

Employer______________________________________

Address of Employer____

City__________________________________State_________Zip Code____________

Family Doctor____________________________ Address of Family Doctor______________________________________

PRIMARY INSURANCE INFORMATION

Company Name__________________________________Address____

Group Number__________________________________ Policy/ID Number_______________________________________

Policy Holder Name________________________________Policy Holder Date of Birth________/______/______

Policy Holder Address____

City__________________________________ State_____________________ Zip Code________

Policy Holder SSN:________/______/_________

Place of Employment______________________________________

Patient's relationship to card holder_______________________

SECONDARY INSURANCE INFORMATION

Company Name__________________________________Address____

Group Number__________________________________ Policy/ID Number_______________________________________

Policy Holder Name________________________________Policy Holder Date of Birth________/______/______

Policy Holder Address____

City__________________________________ State_____________________ Zip Code________

Policy Holder SSN:________/______/_________

Place of Employment______________________________________

Patient's relationship to card holder_______________________

(PLEASE TURN FORM OVER AND COMPLETE OTHER SIDE)

RELATIVE INFORMATION

Nearest relative (not living with you)____

Home Phone________/____________ Work Phone________/____________________

Whom may we contact in case of any emergency?____

REFERRAL INFORMATION

Were you referred to this clinic? (Y / N) If so, by whom?____

RELEASE OF INFORMATON STATEMENT

I authorize Allergy & Asthma of Illinois, SC to release all necessary medical records or other information about me or my medical benefits claims to my insurance companies or their intermediaries or carriers. I permit a copy of this authorization to be used in place of the original.

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Signature of Patient or Guardian of Patient Date

FINANCIAL AGREEMENT

I acknowledge that financial responsibility for bill payment rests solely with the patient or his/her family regardless of any insurance coverage. I further acknowledge that medical benefits are contracted solely with the insured (i.e. patient/family) and not this office, unless a specific contract has been assigned between Allergy & Asthma of Illinois, SC and my insurance carrier or health plan. In the event that I fail to make timely payment in full, or if I fail to make a reasonable payment arrangement and my account becomes past due, I shall be liable for and I agree to pay, all collection agency fees (not to exceed 33.3%), reasonable attorney's fees and court costs.

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Signature of Patient or Guardian of Patient (must be 18 years or older to sign) Date

RELEASE OF INFORMATION VIA FAX

I release Allergy & Asthma of Illinois, SC to fax any of my personal health information to any other Health Care Provider that either Dr. Stephen Smart or Dr. Penelope Ewbank deems necessary for my continuing health care.

Please circle YES or NO

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Signature of Patient or Guardian of Patient Date