Mercer Allergy & Asthma Center ◆ Initial Patient Registration Form

(Please Print)

Date:_____ Referral for specialist needed? Yes ☐ No ☐

Primary Care Physician:_____

Address: _____

Office Phone: ( ) _____

Office Fax: ( ) _____

Pharmacy Name:_____

Address: _____

Phone: ( ) _____

Fax: ( ) _____

Mail Order Co. & ID #:_____

PATIENT INFORMATION

Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐

Patient's Last Name: _____

Patient's First Name: _____ MI _____

Street Address: _____

City, State, Zip: _____

Home Phone: ( ) _____

Cell Phone: ( ) _____

Marital Status: Single ☐ Married ☐ Div ☐

Wid ☐ DP or CU ☐

Birth Date: _____ Age: _____

Sex: Male ☐ Female ☐

Social Security Number: _____

Email Address:

_____

Occupation: _____ Employer: _____ Town:_____

Referred to this practice by: Dr._____ or chose this practice because of: Insurance Plan ☐
Family ☐ Friend ☐ Yellow Pages ☐ Convenient Location ☐ Internet ☐ Other (please specify)_____

IN CASE OF EMERGENCY

Name of Emergency Contact: _____ Relationship to Patient: _____

Home Phone: ( ) _____ Cell/Work Phone: ( ) _____

The above information is true and 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 understand it is my responsibility to keep track of necessary office referrals. I will be financially responsible for any unaccounted visits.

Date:_____ Patient/Guardian Signature_____

HIPAA ACKNOWLEDGEMENT

I, _____ (patient/guardian) acknowledge that I have received, and read, a copy of Mercer Allergy & Asthma Center's notice regarding privacy of personal health information. I consent that messages regarding my health can be left on my home answering machine and/or my cell phone voice mail. The following person(s) are not authorized to my health records:

_____

Date:_____ Patient/Guardian Signature_____

AUTHORIZATION & RELEASE OF INFORMATION

I hereby authorize Mercer Allergy & Asthma Center, LLC to release any records including information regarding diagnosis/treatment to my insurance company in order to process my claims, any physician, or any person involved with my health as acknowledged by the HIPAA Notice of Privacy Practices. I authorize payment of benefits to the physician or supplier for services rendered. I also request the release of payment to be made directly to Mercer Allergy & Asthma Center, LLC. This information is on file as a permanent record.

Date: _____ Print Name:_____ Patient/Guardian Signature_____