Minnesota
Allergy & Asthma
Clinic, PA

Name:_____ DOB:_____
Marital Status:_____ Gender:_____ Race/Ethnicity:_____
Country of Origin:_____ Primary Language:_____
Patient Address:_____ City/State/Zip:_____
Home Phone:_____ Mobile Phone:_____
Responsible Party Name:_____
Responsible Party Address:_____
Email Address:_____

Emergency Contact Name/Relationship:_____/_____
Emergency Contact Phone Number:_____
Primary Physician:_____/Referring Physician:_____

Primary Insurance
Insurance Company:_____
Office Visit Copay:_____
Subscriber Name:_____
Subscriber DOB:_____
Subscriber ID/Group Number:_____
Relationship to Patient:_____
Employer:_____

Secondary Insurance
Insurance Company:_____
Office Visit Copay:_____
Subscriber Name:_____
Subscriber DOB:_____
Subscriber ID/Group Number:_____
Relationship to Patient:_____
Employer:_____

Initial:_____ I acknowledge that the above information is correct and authorize Minnesota Allergy & Asthma Clinic, PA to bill my insurance. I also authorize my insurance carrier to pay Minnesota Allergy & Asthma Clinic, PA directly for services they have provided me. **I understand failure to provide complete insurance information to Minnesota Allergy & Asthma Clinic, PA within ten (10) days of service; I will be responsible for all charges on the account.**

Signature:_____ Date:_____