New Patient Information

(Please Print Clearly)

Allergy & Asthma Affiliates, P.C.
2121 Highland Avenue
Knoxville, TN 37916

PATIENT'S NAME (First Name, Middle Name, Last Name)	☐ Male ☐ Female	**SS #**	**DATE OF BIRTH** / /	**AGE**
STREET ADDRESS		**CITY**	**STATE**	**ZIP**
MARITIAL STATUS ☐ Single ☐ Divorced ☐ Married ☐ Widowed	**HOME PHONE #** ( )	**MOBILE PHONE #** ( )	**E-MAIL ADDRESS** (Optional)	

PERSONAL PHYSICIAN (First & Last Name)			**REFERRING PHYSICIAN** (First & Last Name) ☐ Same as Personal Physician		
STREET ADDRESS			**STREET ADDRESS**		
CITY	**STATE**	**ZIP**	**CITY**	**STATE**	**ZIP**
PHONE # ( )			**PHONE #** ( )		

DRUG ALLERGIES ☐ No Known Drug Allergies

EMPLOYER ☐ Not applicable	**OCCUPATION** (Note if Student)	**PHONE #** ( )
EMPLOYER'S ADDRESS	**CITY**	**STATE** / **ZIP**
SPOUSE'S NAME (First & Last) ☐ Not applicable	**EMPLOYER**	**WORK PHONE#** ( )
EMPLOYER'S ADDRESS	**CITY**	**STATE** / **ZIP**
EMERGENCY CONTACT (If a minor, other than parent or guardian)	**RELATIONSHIP TO PATIENT**	**DAYTIME PHONE #** ( ) ☐ Home ☐ Work

HOW DID YOU INITIALLY LEARN ABOUT OUR PRACTICE?
☐ Referred by another doctor ☐ Referred by a family member or friend ☐ Yellow Pages
☐ Local Advertisement ☐ Other _____

Has a family member been in our office before? If so, who?

IF PATIENT IS A MINOR OR A STUDENT PLEASE COMPLETE THIS SECTION. ☐ NOT APPLICABLE

MATERNAL INFORMATION

CHECK ONE: ☐ Biological Mother ☐ Step-Mother ☐ Foster Mother ☐ Legal Guardian – Relationship _____ (Please provide guardianship documents)

MOTHER'S NAME (First & Last Name)	**SS#**	**HOME PHONE #** ☐ Same as patient ( )	**MOBILE PHONE #** ( )
STREET ADDRESS ☐ Same as patient	**CITY**	**STATE**	**ZIP**
MOTHER'S EMPLOYER	**OCCUPATION**	**WORK PHONE #** ( )	

PATERNAL INFORMATION

CHECK ONE: ☐ Biological Father ☐ Step-Father ☐ Foster Father ☐ Legal Guardian – Relationship _____ (Please provide guardianship documents)

FATHER'S NAME (First & Last Name)	**SS#**	**HOME PHONE #** ☐ Same as patient ( )	**MOBILE PHONE #** ( )
STREET ADDRESS ☐ Same as patient	**CITY**	**STATE**	**ZIP**
FATHER'S EMPLOYER	**OCCUPATION**	**WORK PHONE #** ( )	

BILLING INFORMATION (Please note: In divorce situations the parent accompanying the patient will be responsible for any services not covered by insurance.)

PARTY RESPONSIBLE FOR PAYMENT AFTER INS. COVERAGE (Full Name)	**DATE OF BIRTH** / /	**SS#**	**HOME PHONE #** ( )
PLACE OF EMPLOYMENT	**OCCUPATION**		**WORK PHONE #** ( )

Completed by:_____ **Date**: _____/_____/_____ **Relationship to patient:** _____

*****PLEASE COMPLETE INFORMATION ON REVERSE SIDE*****

INSURANCE INFORMATION Please complete **exactly** as it appears on the cardholder's insurance card(s).

Primary Plan

☐ Mr. ☐ Ms.	**CARDHOLDER'S NAME** (Exactly as it appears on card)		
SS#	**DATE OF BIRTH** / /	**RELATIONSHIP TO PATIENT**	
MEMBER ID #	GROUP #	**REFERRAL REQUIRED?** ☐ NO ☐ YES CO-PAY REQUIRED? ☐ NO ☐ YES AMOUNT $ _____ DO YOU HAVE A DEDUCTIBLE? ☐ NO ☐ YES AMOUNT $ _____	
INSURANCE COMPANY (PRESENT CARD AT EACH VISIT)		**PHONE #** (SEE BACK OF CARD)	
CLAIMS ADDRESS	**CITY**	**STATE**	**ZIP**

Secondary Plan

☐ Mr. ☐ Ms.	**CARDHOLDER'S NAME** (Exactly as it appears on card)		
SS#	**DATE OF BIRTH** / /	**RELATIONSHIP TO PATIENT**	
MEMBER ID #	GROUP #	**REFERRAL REQUIRED?** ☐ NO ☐ YES CO-PAY REQUIRED? ☐ NO ☐ YES AMOUNT $ _____ DO YOU HAVE A DEDUCTIBLE? ☐ NO ☐ YES AMOUNT $ _____	
INSURANCE COMPANY (PRESENT CARD AT EACH VISIT)		**PHONE #** (SEE BACK OF CARD)	
CLAIMS ADDRESS	**CITY**	**STATE**	**ZIP**

AGREEMENT AND CONSENT FOR MEDICAL SERVICES

1. Agreement and Consent. I am the parent or legal representative of [ ] (the "Patient") and am authorized to act on his/her behalf. I hereby authorize medical services to be provided to the Patient by the physicians and medical staff of Allergy & Asthma Affiliates, P.C. until revoked by me in writing.

2. Release of Information. I hereby authorize Allergy & Asthma Affiliates, P.C. to release to governmental agencies, third party payors and other agencies, any information reasonably requested by such parties, including any information necessary for Allergy & Asthma Affiliates to obtain payment for services provided.

3. Assignment of Insurance Benefits. I authorize and request that payment be made directly to Allergy & Asthma Affiliates, P.C. for any insurance benefits payable for services provided to the Patient by Allergy & Asthma Affiliates, P.C. This authorization expressly includes any benefits that are to be provided by TennCare and any other public or private insurance plans. This order will remain in effect until revoked by me in writing. If my current policy prohibits direct payment to Allergy & Asthma Affiliates, P.C., then I hereby do also instruct and direct that payment be made out to me and mailed as follows:

Allergy & Asthma Affiliates, P.C.
2121 Highland Avenue
Knoxville, TN 37916

4. Acknowledgement of Financial Responsibility. While there may be insurance benefits available to pay for the medical services provided to the Patient by Allergy & Asthma Affiliates, I understand that all services may not be covered by insurance, or that payment may be less than 100% of the charges billed. I agree to pay any required co-pay amount and any deductible amount at the time of service. I further agree to pay for any services rendered by Allergy & Asthma Affiliates, P.C. for the Patient, which are not paid or not covered by insurance.

5. Acknowledgment of Notice of Privacy for PHI. I, _____ (patient / parent / guardian), acknowledge that I have received a copy of Allergy & Asthma Affiliates' Notice Regarding Privacy of Personal Health Information.

_____ ____/____/____ _____

Signature of Patient / Parent / Guardian | Date | Relationship to Patient