ALLERGY AND ASTHMA INSTITUTE OF JOHNS CREEK

REGISTRATION FORM (v10.31.2011)

PATIENT INFORMATION

Patient Last Name:	First:	Middle:	☐ Married ☐ Single	☐ Male ☐ Female	Date of Birth: / /	Age:
Parent or Legal Guardian (if applicable):			Home Phone #: ( )		Cell Phone #: ( )	
Street Address:			Work Phone #: ( )		Preferred Method of Contact: ☐ Phone ☐ eMail	
P.O. box:	City:	State:	ZIP Code:	eMail:		

Race (check all): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Unreported/Refused

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Unreported/Refused to report

Language(s): ☐ English ☐ Spanish ☐ Other:

Referral Source: ☐ Primary Care Physician ☐ Other Physician ☐ Website ☐ Insurance Plan ☐ Family/Friend ☐ Advertisement

Primary Care Physician:	Name of Medical Practice and Location:	Phone #: ( )
Other Physician:	Name of Medical Practice and Location:	Phone #: ( )
Pharmacy:	Location:	Phone #: ( )

INSURANCE INFORMATION (Please give your insurance card to the receptionist)

Person Responsible for Bill:	Birth Date: / /	Address (if different):	Home Phone #: ( )
Occupation:	Employer:	Employer Address:	Employer Phone #: ( )

Method of Payment Today: ☐ Self Pay ☐ Insurance

Please Indicate Primary Insurance: ☐ Aetna ☐ Amerigroup ☐ Blue Cross/Blue Shield (BCBS) ☐ Cigna ☐ Coventry ☐ Humana ☐ Medicare ☐ Peach State ☐ United Healthcare (UHC) ☐ WellCare ☐ Other:_____

Subscriber's Name:	Birth Date: / /	Group #:	Policy #:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Secondary Insurance:	Subscriber's Name:	Birth Date: / /	Group #:	Policy #:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

IN CASE OF EMERGENCY

Emergency Contact Name:	Relationship to Patient:	Home Phone #: ( )	Work/Cell 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 Allergy and Asthma Institute of Johns Creek to release any information required to process my claims.

Please be aware that this office does not use an answering service after business hours. If you need emergency assistance after the office has closed, please go to your nearest emergency room.

Patient/Guardian Signature:_____ Date:_____