

CINCINNATI ALLERGY AND ASTHMA CENTER, INC.

Patient Registration Form

Appointment Date/ Time/ Doctor / Location: _____

Patient's Name: _____ Nickname: _____
(Last) (First) (Middle)

Patient's Address: _____

City: _____ State: _____ Zip: _____

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

Birth Date: _____ M F Age: _____ Social Security Number: _____

Marital Status: Single Married - Spouse's Name: _____ Occupation: _____ Daytime Ph. # _____
 Separated/Divorced Widowed

Employer: _____ Occupation: _____

Primary Care Physician: _____ Phone: _____

Other Physician (s) who care (s) for you and to whom we may disclose information regarding your care _____
Phone _____

Emergency Contact: Name: _____ Address: _____

Phone: (H) _____ (W) _____

If patient is a minor, please provide parental information:

Mother's Name: _____ SS# _____ Employer: _____

Emp. Address: _____ Daytime Ph. #: _____ Occupation: _____

Father's Name: _____ SS# _____ Employer: _____

Emp. Address: _____ Daytime Ph. #: _____ Occupation: _____

INSURANCE INFORMATION

Primary Insurance: _____ Effective Date: _____

Insurance Company: _____

Address: _____

Subscriber Name: _____

ID# _____ DOB _____

Group Policy #: _____

Secondary Insurance: _____ Effective Date: _____

Insurance Company: _____

Address: _____

Subscriber Name: _____

ID# _____ DOB _____

Group Policy #: _____

INSURED CARDHOLDER OR OTHER FINANCIALLY RESPONSIBLE PARTY (if patient-simply write "Patient" , if parent, simply write "Mother", "Father", in the space provided for "Name" and complete "*", otherwise fill out completely).

I, _____ (Print Name), will assume all financial responsibilities.

SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone:() _____ Daytime Phone: _____

Employer: _____ Employer Address: _____

*Relationship to insured/ patient: _____
(Husband/Wife/Son/Daughter/Self)

***Signature:** _____ **Date:** _____

The parent or guardian authorizing treatment, then you are the person financially responsible for any uncovered expenses.

STAFF USE ONLY

- Have patient sign below yearly ONLY IF NO CHANGE with information above

***Signature:** _____ **Date:** _____

The parent or guardian authorizing treatment, then you are the person financially responsible for any uncovered expenses.

***Signature:** _____ **Date:** _____

The parent or guardian authorizing treatment, then you are the person financially responsible for any uncovered expenses.