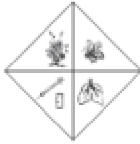

Allergy Institute, P.C.
Pediatric & Adult Allergy, Asthma, & Immunology
1701 22nd St, Suite 207
West Des Moines, IA 50266
Phone: 515-223-8622

Office Use Only:
Account No: ______________

Employer: ______________________ **Patient Information** **Today's Date:**____________

Last: ____________________ **First:** ____________________ **Middle:** _____________ **Birthdate:** ___________

Marital Status (circle) S M D W **Social Sec. No:** ____________________ **Sex** (Circle) : Male Female

Address: ______________________ **Phone No:** (circle) Mobile Home **Email Address:**
City: _________________________
State/Zip: _____________________ __________________________ ____________________________

Race (circle): Caucasian, African-American, Asian, Native American, Pacific Islander
Ethnicity: Hispanic/Latino or Non-Hispanic

Parent/Guardian Information (for minors)
Mother: _____________________ **Phone:** _______________
Father: ______________________ **Phone:** _______________

Referring Provider: ____________________________ **Primary Care Provider:** _________________________

Personal Financially Responsible Information (SKIP to below if SAME as above)

Name: ____ Relationship to Patient: __________________

Social Sec. No: _______________ Birthdate: ___________ Sex (circle): Male or Female

Address: ____ Phone: ______________________

Employer: ____ Marital Status (circle): S M D W

Primary Insurance Information

Primary Insurance: __________________ Subscriber Name: ______________________ Birthdate: _________

Subscriber Home Address: ____

Relationship to Patient: ______________________ Social Sec. No: ______________________

Subscriber Employer: _______________________ Policy No. _______________ Group No. _______________

Secondary Insurance Information

Secondary Insurance: ________________ Subscriber Name: ______________________ Birthdate: _________

Subscriber Home Address: ____

Relationship to Patient: ______________________ Social Sec. No: ______________________

Subscriber Employer: _______________________ Policy No. _______________ Group No. _______________

In Case of Emergency

Name: _______________________ Relationship to Patient: _______________ Phone No: ________________

The above information is true to the best of my knowledge. I authorize Allergy Institute to bill my insurance and contact me via text/email regarding my appointment.

Patient/Guardian Signature: ______________________________ Date: ________________________

ALLERGY INSTITUTE, P.C.

RELEASE OF INFORMATION TO INSURANCE

By signing the release below, this allows Allergy Institute to expedite the insurance claims for services provided by our providers.

I, _______________________________(Print Patient Name) hereby authorize the release of any medical information necessary to process health insurance claims for services provided by Allergy Institute, P.C. This authorizes Allergy Institute P.C. to disclose information to the insurance companies regarding my health and treatment.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I UNDERSTAND THAT THE ULTIMATE RESPONSIBILITY AND FINANCIAL OBLIGATION FOR THE SERVICES RENDERED BY ALLERGY INSTITUTE, P.C. BELONGS TO ME.

I understand that I am financially responsible to pay Allergy Institute P.C. its usual charges for all services received through Allergy Institute. P.C., including any balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to Allergy Institute, P.C. and direct that payment of proceeds to Allergy Institute, P.C.

____

Patient/Legal Guardian Signature **Date**

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that there is a "Notice of Medical Information Privacy Rights" that is available at www.allergyinstitutepc.com for me to review or I can be given a paper copy on request.

____

Patient/Legal Guardian Signature **Date**

Ver. 4/5/18

ALLERGY INSTITUTE, P.C.

Consent to Use and Disclose of Protected Health Information

Name:______________________________ Date of Birth:___________________________

Please fill out the following list, so we can effectively reach you regarding medical appointments, medical care, lab results, billing etc.

Home Phone_______________________ Work Phone________________________________

Cell ______________________________ E-Mail_____________________________________

I understand that every effort will be made to contact me directly regarding appointments, lab/test results, billing, etc and that messages may be left on my phone. In the event Allergy Institute, P.C. is unable to contact me, I give my permission to contact the following individual(s) and discuss my health care information with them.

☐ I do NOT want any other person to have access to my medical care.

☐ I give my permission for the following person(s) to receive information regarding my appointments and medical care.

Name________________________ Phone_____________________ Relationship_____________

Name________________________ Phone_____________________ Relationship_____________

I give Allergy Institute, P.C. permission to leave a message on an answering machine.

I understand that I have the right to change or revoke this information at any time.

Patient/Guardian Signature________________________________ Date_________________

Ver. 4/5/18