Welcome To Park Allergy Center
2017 PATIENT INFORMATION

PLEASE NOTE: If you are covered under your parent's, step-parent's or spouse's insurance no matter patient's age we must have your spouse's or parent's information to file insurance claims

Last Name:_____First Name:_____ Middle Initial:____

Nickname:_____ Male _____ Female _____ SS#:_____-_____-_____

Street Address:_____ City: _____State: _____Zip:_____

Birthdate _____Age_____ Marital: single married widowed divorced Email:_____

Home Phone:_____ Cell:_____ Circle which phone to leave messages: Home Cell Work

Employer: _____Occupation: _____Work Phone:_____

Primary Physician:_____Referring Physician:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Spouse Information

Spouse:_____ Birthdate _____SS#_____-_____-_____

Employer:_____Phone#'s: Home:_____ Cell:_____Work:_____

******Parent information - All patients under 18 must have both parent's information filled out********

Father:_____Birthdate:_____SS#_____-_____-_____ Married Single Divorced

Street Address:_____ City: _____State: _____Zip:_____

Employer:_____Phone#'s: Home:_____ Cell:_____Work:_____

Mother:_____Birthdate:_____SS#_____-_____-_____ Married Single Divorced

Street Address:_____ City: _____State: _____Zip:_____

Employer: _____Phone#'s: Home:_____ Cell:_____Work:_____

Please fill out step-parent's information if needed for insurance or contact information

Step-Parent:_____Birthdate: _____SS#_____-_____-_____ Is married to Father or Mother

Street Address:_____ City: _____State: _____Zip:_____

Employer: _____Phone#'s: Home:_____ Cell:_____Work:_____

Primary Insurance: Who supplies your Primary Insurance (please check one)

O My employer O Spouse's employer O Father's employer O Mother's employer O Step-Parent's employer O Self Insured

Primary Insurance:_____ Subscriber ID#:_____ Group#:_____

Do you have secondary insurance? Please circle Yes or No If yes, Who supplies your Secondary Insurance (please check)

O My employer O Spouse's employer O Father's employer O Mother's employer O Step-Parent's employer O Self Insured

Secondary Insurance:_____ Subscriber ID#:_____ Group#:_____

I hereby authorize Park Allergy Center, PC to examine and treat me or my child and to perform such diagnostic tests as may be necessary for the duration of this illness. I hereby authorize the release of any medical information necessary to process my insurance claims. I understand the medical information may include information related to the diagnosis and/or treatment of alcohol/substance abuse, psychological/mental disorders and or HIV serostatus. I hereby authorize for any benefits payable under my policy be paid directly to Park Allergy Center. Unless you specifically request a refund of any credit balance, all refunds and overpayments less than $25 will be applied as a credit on the patient's account and will be treated as unclaimed property under Michigan law if not used within three (3) years. All other credit balances will be refunded to you.

I understand that I am ultimately responsible for all charges, copays, deductibles, co-insurance and remaining balances not paid or covered by my insurance.

Signature of PATIENT (or Guardian):_____Date_____

Guardian's Printed Name:_____ Relationship to Patient:_____