Daher Asthma and Allergy Clinic **How did you hear about us??_______________**

Patient Registration Form: **Are you a new patient today? Y__ N___**

LAST NAME	**FIRST NAME**	**Date of Birth:** ____________ **SSN:** ____________________
MAILING ADDRESS:	**Preferred Emergency Contact** _______________________ Tel # ____________________	**PHONE NUMBER** CeLL: Home: (mark**preferred)
MARITAL STATUS Single__ Married __ Divorced__ Widowed__	**SPOUSE'S NAME:** __________________________ Tel # ___________________	**PATIENT EMAIL ADDRESS** _________________________ **Race /Ethnicity** _____________
Employer Name: _________________________ **Address:** _________________	**REFERRING PROVIDER:** _______________________ Tel # ____________________ **Do you have a referral Y__N__**	***Pharmacy Name /#*** ________________________ ***Do you have a living will or Advance Directive? Y__N___***
Primary Insurance Company __________________________ **Policy ID #_________________**	**Policy Group #** _________________________ **Ins Tel #** _________________ **Ins Address:**	**Secondary Insurance: Y__ N__** **Sec ins Policy #** ___________________________
Policy holder	**Policy holder DOB**	**Relation to Policy Holder**

<u>IF PATIENT IS MINOR:</u>

Father's Name _____________________________ **SSN**_____________________

Father's Occupation _______________________**Employer's Address** ___________________________

Mother's Name _____________________________**SSN**____________________________________

Mother's Occupation _______________________**Employer's Address** ___________________________

<u>Assignment of Benefits:</u>

I authorize payment of any insurance benefits for services rendered by Daher Asthma and Allergy Clinic PLLC to be paid directly to Daher Asthma and Allergy Clinic PLLC and its physicians.

<u>Release of Information:</u>

The patient (or parent or authorized representative) consents to the use and disclosure of info relating to the services provided by the Daher Asthma and Allergy Clinic PLLC for the purpose of treatment, payment or healthcare operation, including submission of a claim for medical benefits to a provider or administrator of medical benefit plans. This remains valid as long as the patient is under medical care at this facility. You may receive a copy of this. If you chose to revoke this consent in writing, previous to that date any action taken in accordance with this consent will not be revoked. If this is revoked or there is refusal to sign this consent, Daher Asthma and Allergy Clinic may decline to provide or continue to provide treatment.

Authorized Signature: ____________________________________ **Date:** ___________________________

Name of Authorized Signature: __________________________________ **Relationship if not patient**___________________________