



Allergy and Asthma Consultants

Brian S. Lipson, M.D. FAAAAI
Diplomate, American Board of Allergy and Immunology

Patient Information
(Please Print)

Date _____ Account # _____
Patient Name _____
Address _____ Phone () _____
City/State _____ Zip _____
Social Security # _____ Date of Birth _____ Sex _____
Driver's License # _____
Patient's Employer _____
Address _____
Spouse's Name _____
Spouse's Employer _____
Address _____ Phone () _____

Responsible Party

In Case of Emergency Contact:

Name _____	Name _____
Address _____	Address _____
Phone () _____	_____
Employer _____	Phone () _____
Address _____	
Phone () _____	
Referred to this office by _____	Primary Physician _____

INSURANCE

PRIMARY

Name _____ Policy # _____ Subscriber _____
Address _____

SECONDARY

Name _____ Policy # _____ Subscriber _____
Address _____

PLEASE HAND RECEPTIONIST YOUR INSURANCE CARD(S)

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

METHOD OF PAYMENT: CASH _____ CHECK _____ CREDIT CARD _____

PLEASE READ AND SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to _____ and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE _____ DATE _____