PIKES PEAK
Allergy & Asthma

Patient Information Form

Date: Check One: ☐ *Annual* ☐ *Name/Address Change* ☐ *Insurance Change* ☐ *New Patient*

PATIENT NAME: **DATE OF BIRTH:**

Mailing Address:

City: State: ZIP:

Home Telephone: ( ) E-mail address:

Mobile Telephone: ( ) Okay to contact via Text Message: ☐ *Y* ☐ *N*

Employer: Occupation:

Work Telephone: ( ) Okay to contact at work: ☐ *Y* ☐ *N*

SSN: Marital Status: ☐ *Married* ☐ *Single* Gender: ☐ *M* ☐ *F*

Race: ☐ *Caucasian* ☐ *African-American* ☐ *Hispanic* ☐ *Asian* ☐ *Other*

Emergency Contact: Relationship to Patient:

Home Telephone: ( ) Mobile Telephone: ( )

Primary Care Physician: Telephone: ( )

Address:

How did you hear about our office:

PRIMARY INSURANCE

Insurance Company Name:

Name of Policy Holder (Insured): DOB:

Policy Holder (Insured) ID Number: Group #:

SECONDARY INSURANCE

Insurance Company Name:

Policy Holder (Insured) Name: DOB:

Policy Holder (Insured) ID Number: Group #:

By signing below, I am stating that the above information is true. I authorize Pikes Peak Allergy & Asthma to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to Pikes Peak Allergy & Asthma for services rendered. I am responsible to pay non-covered servcies. Claims not paid by the Insurance Company after 60 days will be forwarded to me for payment.

Signature (Patient or Guardian): Date:

Relationship to Patient:

01/20