PIKES PEAK
Allergy & Asthma

Patient Information Form

Patient Name: **Date of Birth:**

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

Mailing Address:

City: State: ZIP:

Home Telephone: ( ) Mobile Telephone: ( )

SSN: Email Address:

Marital Status: ☐ *Married* ☐ *Single* Gender: ☐ *Male* ☐ *Female*

Employer: Occupation:

Work Telephone: ( )

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:

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