



INTERNAL USE ONLY

Chart/ Account # _____

Doctor _____

Date _____

Account Type _____

NEW PATIENT INFORMATION

PATIENT _____ **SOCIAL SECURITY NO.** _____
(Last) (First) (M)

Address _____
(Street or Route) (City) (State) (Zip) (County)

Home Phone _____ Date of Birth _____ Age _____ Sex _____ Marital Status _____

Occupation _____

EMPLOYER _____ Business Phone _____

Employer's Address _____
(Street or Route) (City) (State) (Zip) (County)

REFERRING DOCTOR _____ **PRIMARY DOCTOR** _____

Address _____ Address _____

How did you learn about us? Doctor Referral Friend Yellow Pages Radio Newspaper Other _____

RESPONSIBLE PARTY (If other than Patient) _____

Address _____
(Street or Route) (City) (State) (Zip)

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY: _____

PHONE: _____ **ADDRESS:** _____
(Street or Route) (City) (State) (Zip)

IS THIS A WORK RELATED VISIT? YES _____ NO _____

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____

Address _____ Address _____

City & State _____ City & State _____

Name of Policyholder _____ Name of Policyholder _____

Policy ID Number _____ Policy ID Number _____

Group ID Number _____ Group ID Number _____

Does Your Insurance Company require Prior Authorization for Hospitalization Yes _____ No _____

INSURANCE AUTHORIZATION AND ASSIGNMENT
I hereby authorize Dakota Allergy and Asthma to furnish information to my insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself and my dependents. I understand that it is my responsibility to pay for all charges for the services incurred. It is my responsibility to inform you if my insurance company requires prior authorization for hospitalization.

Signature _____
Date _____

MEDICARE AUTHORIZATION AND ASSIGNMENT
I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature _____
Date _____