

PATIENT DEMOGRAPHIC FORM - 2008

ACCT #

DATE

PATIENT INFORMATION

Last Name	First Name	Initial	Nickname
Date of Birth	Social Security Number	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="checkbox"/> LEGAL Domestic Partner	<input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other
Home Address	Apt. #	City	State Zip Code
Home Phone	Work Phone	Cell Phone	
Employer	Employer Phone		
Email Address	Occupation:		

IF PATIENT IS A MINOR CHILD, PLEASE COMPLETE THIS SECTION

Mother's Name	<input type="checkbox"/> Custodial Parent	Father's Name	<input type="checkbox"/> Custodial Parent
Mother's Home & Cell Phone Numbers	Father's Home and Cell Phone Numbers		
Mother's Employer/Phone Number-Ext	Father's Employer/Phone Number-Ext		

RESPONSIBLE PARTY/INSURANCE INFORMATION

Relationship to Patient	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Parent	<input type="checkbox"/> Other
Last Name	First Name	Initial		
Date of Birth	Social Security Number	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Home Address	Apt. #	City	State	Zip Code
Home Phone	Work Phone	Cell Phone		
Employer	Employer Phone			
Insurance Company/Phone Number	Identification Number	Group Number		
Subscriber/Policy Holder	Subscriber/Policy Holder's Date of Birth	Relationship to Patient		

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

Last Name	First Name	Relationship to Patient
Home Address	Apt. #	City State Zip Code
Home Phone	Work Phone	Cell Phone

PHYSICIAN/REFERRAL INFORMATION

Who may we thank for your referral?	
Primary Care Physician/Phone Number	Referring Physician/Phone Number

****FAMILY MEMBERS ****

Please list Family Members who are patients in our office:

ALLERGY & ASTHMA CENTER OF AUSTIN

William C Howland, III MD

Allen K Lieberman, MD

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
FINANCIAL AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION**

I have received Allergy & Asthma Center of Austin's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I give my consent for AACA to discuss patient's medical care and payment for medical care with the following people:

Name/Relationship/ Phone Number	Name/Relationship/Phone Number

I authorize Allergy & Asthma Center of Austin to release any information in the course of my examination or treatment to my insurance company. I further authorize any benefits due for services rendered to be paid directly to William C Howland III, MD, Allen K Lieberman MD and/or Allergy & Asthma Center of Austin.

I Hereby agree to pay any charges, deductibles and/or co-payments not paid for by my insurance plan that are deemed to be my responsibility for services rendered by the physicians and/or staff at the Allergy & Asthma Center of Austin. Furthermore, I agree to pay my portion at the time services are provided. I understand I am responsible for obtaining and providing all referral authorizations to the Allergy & Asthma Center of Austin in accordance with my insurance plan provisions. I authorize Allergy & Asthma Center of Austin to submit claims on my behalf. I agree to notify Allergy & Asthma Center of Austin immediately of any change in the status of my insurance plan, benefits or primary care physician. I understand failure to do so could result in non-payment by my insurance company and I would then be responsible for ALL unpaid charges.

Allergy & Asthma Center of Austin requires a 24-hour notice for appointment cancellations. I understand after the first failure to keep an appointment, I may be subject to a \$25.00 charge for any following missed appointments without proper notification.

PATIENT/PARENT/GUARANTOR SIGNATURE

DATE

PRINTED NAME OF PATIENT

RELATIONSHIP TO PATIENT