**Patient Information**

Today’s date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for choosing our office! To serve you properly, we need the following information.

All of this information will be kept confidential.

**Patient Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **M**\_\_ **F**\_\_

Responsible Party (If different than patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Responsible Party’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient mailing address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it okay to leave a detailed message? Yes \_\_\_\_ No \_\_\_

Mobile Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it okay to leave a detailed message? Yes \_\_\_\_ No \_\_\_

Is it okay for us to send you text messages regarding your appointment and/or prescriptions? Yes \_No \_

Email Address (Used for the patient portal)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer (Patient/Parent/Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: (Circle one) Minor S M W D Patient/parent Social Security Number \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_

Emergency Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (for Emergency Contact) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Race \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patients Ethnicity: (Circle One) Hispanic or Non-Hispanic

Language Preference \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If the patient is under 18 years of age, please complete the following:**

Father’s Name (Male Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lives with child? Yes \_\_ No\_\_

Mother’s Name (Female Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lives with child? Yes\_\_ No\_\_

**Insurance Information:**  
Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID No. \_\_\_\_\_\_\_\_\_\_\_\_\_

(Fill out the following information if the patient in not the policy holder)

Policy holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID No. \_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_

**LIMITS OF CONFIDENTIALITY**

By signing below, you are authorizing treatment and the release of medical information necessary to process

your insurance claim. You are also authorizing the release of your medical information to referring doctors

and/or insurance companies on behalf of Grand Traverse Allergy, PC. If applicable this authorizes us to bill Medicare

and release any information needed to determine payment for any specific date of service.

\_\_\_\_\_\_\_\_\_PLEASE CHECK HERE IF WE ARE AUTHORIZED TO SHARE MEDICAL INFORMATION WITH ANY

IMMEDIATE FAMILY MEMBERS. IF SO, THEN PLEASE LIST NAMES OF PERSONS THAT ARE AUTHORIZED TO

RECEIVE INFORMATION.

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL POLICIES**

1. It is our office policy for you to pay your co-payment at the time of service unless other arrangements have

been made. It is your responsibility to know how much your co-pay is. Payment methods available are Cash,

Check, MasterCard, Visa, or Discover.

2. We will bill all primary insurances for you; however, you will be responsible for all co- pays, deductibles, and

any balance that your insurance does not cover.

3. It is your responsibility to make sure that you have any necessary referrals or authorizations that are

required for your insurance from your primary care physician prior to being seen in our office. If you are not

sure if a referral or authorization is needed, please check with your insurance before your appointment.

4. Please be sure that you have your current insurance card and identification with you at your visit. If we are

not provided with a copy of these your insurance may not be billed until we have them.

5. It is your responsibility to know your insurance coverage prior to treatment (i.e.: allergy testing, office visits,

allergy injections, allergy serum) as some insurance policies do not have allergy coverage.

6. Regardless of your insurance status, you are ultimately responsible for the balance of your account for all

services rendered.

**I have read and understand the above statements and have been offered the Notice of Privacy Practice in**

**regard to my protected health information at Grand Traverse Allergy, PC.**

Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_