REGISTRATION
(PLEASE PRINT)

AUSTIN ALLERGY ASSOCIATES

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Austin, TX 78731
512-458-9191 / 512.458-2330 fax

DATE_____ **HOME PHONE (____)**_____ **CELL PHONE (____)**_____

PATIENT INFORMATION

Name(Last)_____(First)_____(MI)____Soc. Sec.#_____

Address_____ E-mail_____

City/State/Zip_____ Sex ☐M ☐F Birthdate_____ Age_____

☐Single ☐Married ☐Widowed Race/Ethnicity_____

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Employer/School Phone_____

Whom may we thank for referring you?_____

In case of emergency who should be notified? _____ Phone (_____)_____

PRIMARY INSURANCE

Person Responsible for Account Name(Last)_____(First)_____(MI)_____

Relation to Patient_____ Birthdate_____ Soc. Sec.#_____

Address(If different from patient's) _____ Phone (_____)_____

City/State/Zip_____ Race/Ethnicity_____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (_____)_____

Insurance Company _____

Policy#/Subscriber ID _____ Group# _____

Name of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (_____)_____

City _____ State _____ Zip _____

Insurance Company _____

Policy#/Subscriber ID _____ Group# _____

Name of other dependents covered under this plan

PHARMACY INFORMATION

Pharmacy Name_____ Pharmacy Phone (_____)_____

Address_____ City/State/Zip_____

ASSIGNMENT AND RELEASE

I certify that I, and or my dependent(s), have insurance coverage with _____ and assign directly to Austin Allergy Associates, Dr. Vaughan and or Dr. Dyer, all insurance benefits if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctors may use my health care information and may disclose such information to the above- named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I also acknowledge that I have received a copy of Austin Allergy Associates Notice Regarding Privacy of Personal Health Information.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent Guardian or Personal Representative Relationship to Patient