Allergy Asthma Ear Nose & Throat
2802 Leonard Drive Valparaiso, IN 46383
PH: 219-531-5855 Fax: 219-531-1617

Patient Information:

Name________________________ _________DOB:____/____/____Age____Sex: M___F___

Address___________________________City_________________State________Zip_________

Social Security No__________________Home Phone____________Cell Phone_____________

Employer____________________Work Phone_______________Email____________________

Insurance Information:

Primary Insurance_____________________________Policy ID No_______________________

Address_________________________Group No________________Effective Date___/___/___

Policy Holder's Name____________________DOB___/___/___Social Security No__________

Secondary Insurance___________________________Policy ID No_______________________

Address_________________________Group No_______________Effective Date___/___/___

Policy Holder's Name____________________DOB___/___/___Social Security No__________

Responsible Party:

Name_________________________DOB___/___/___Social Security No__________________

Address_______________________Home No______________Cell No____________________

Emergency Contact

Name________________________Relationship to Patient______________Phone____________

By my signature below I:

(A) Authorize payment directly to Allergy Asthma Care, P.C., for the surgical and/or medical benefits, if any otherwise payable to me for the services; and
(B) Authorize to release information acquired in the course of my examination or treatment to referral physician or your insurance company.
(C) I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name__________________________Signature_______________________Date___/___/___