SHER ALLERGY SPECIALISTS
11200 SEMINOLE BLVD. SUITE 310,LARGO, FL 33778

PATIENT INFORMATION:

Patient Name:______________________________Age:__________Birthday:__________________Sex: M F

Social Security#:__________________________Drivers License#:__________________________State:________

Address (local):__________________________City: __________________St.________Zip Code:____________

Home Phone:______________________Cell Phone:______________________E-Mail:______________________

Employer:__________________________Occupation:____________________Phone:______________________

Address (out of area):______________________City:____________________St.__________Zip Code:__________

Phone (out of area):__________________________ Marital Status: ( ) Single ( ) Married ( ) Other

Spouse information: ( ) OR Emergency Contact ( ) (if not married, please give emergency contact name & phone information)

Name:__________________________________Employer:__________________________________

Occupation:______________________________Phone:____________________________________

PRIMARY INSURANCE INFORMATION: Is this a Workers Compensation Insurance? ( ) YES ( ) NO

Insurance Co:__________________________________Phone :____________________________

Mailing Address:____

Name of Insured:______________________Birthday:______________Social Security#:____________________

Policy #__________________________Group#____________________Employer:______________________

Insureds Relationship to Patient:____________________________

Secondary Insurance Information: Do you have other insurance coverage? ( )YES ( ) NO

Insurance Co:__________________________________Phone :____________________________

Mailing Address:____

Name of Insured:______________________Birthday:______________Relationship to Patient:____________________

Policy #__________________________Group#____________________Employer:______________________

Other Misc. information:

Referred by: * Doctor( ) *Family ( ) *Friend ( ) Phone Book ( ) Insurance Book ( ) Other ( )______________

***Please give name & address:____**

Family Physician(PCP)__________________________________Phone:________________________

Do you have other family members who are patients in our office?____________________Relationship______________

FINANCIAL RESPONSIBILITY, ASSIGMENT OF BENEFITS, AND RELEASE OF PROTECTED HEALTH INFORMATION

- I herby agree to pay **SAS** for all charges (to include co-pays, deductible and co-insurance amounts) at the time of service. I understand that although the office may accept assignment of insurance benefits, the charges ultimately are my responsibility. I realize that if a balance is due necessitating the use of a collection agency, I agree to pay all collection costs, including attorney fees.
- I authorize **SAS** to file insurance claims on my behalf to the company(ies) with which I have coverage to include the Social Security Administration. I authorize payment to be made to **SAS** for services rendered to me.
- I consent to the release of protected health information which may be necessary to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.
- I acknowledge that I have received a copy of **SAS** Health Insurance Portability & Accountability Act (HIPAA) Notice of Privacy Practices.

Patient Signature:____Date:____________________