VIRGINIA ALLERGY & ASTHMA CENTER

PATIENT INFORMATION

Patient Name: _____ SSN: _____
First Last MI

Home Address: _____ PHONE: _____

City/State/Zip: _____

Sex: ☐M ☐F Age: ____ DOB: _____ Race: _____ ☐Single ☐Married ☐Widowed ☐ Separated ☐Divorced

Patient Employer: _____ Business Ph: _____

Employer Address: _____ Occupation: _____

Referred By: _____ Family MD: _____

Emergency Contact Name: _____ EMERGENCY Phone: _____

PRIMARY INSURANCE

Policy Holder: _____ SSN: _____

Relation to Pt: _____ HOME PHONE: _____

Address: _____ Cell Phone: _____

City/State/Zip: _____

Pol Holder Employer: _____ Business Ph: _____

Employer Address: _____ Occupation: _____

Insurance Co.: _____ Ins Co Ph: _____

Ins Co Address: _____ City/State/Zip: _____

Policy Holder's: DOB: _____ Group No: _____ ID No: _____

ADDITIONAL INSURANCE

Policy Holder: _____ SSN: _____

Relation to Pt: _____ Primary Ph: _____

Address _____ Cell Phone: _____

City/State/Zip: _____

Pol HolderEmployer: _____ Business Ph: _____

Employer Address: _____ Occupation: _____

Insurance Co.: _____ Ins Co Ph: _____

Ins Co Address: _____ City/State/Zip: _____

Policy Holder's: DOB: _____ Group No: _____ ID No: _____

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly To VAAC 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 they are paid by insurance. I hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. **I understand that if a referral is required by insurance company it is my responsibility to obtain one from my family physician.** _____

_____ _____ _____

Responsible Party Signature: Date: Relationship / SSN:

_____ I have been provided a copy of Virginia Allergy & Asthma Center's office policies and Hipaa procedures. I will thoroughly read the brochure and abide by the policies set forth by Dr. Vilseck and his staff. (INITIAL)

EMAIL ADDRESS: _____