NEW PATIENT INFORMATION

Name, Last:_____First:_____Middle Initial_____

Preferred Name:_____Date of Birth_____ Age:_____ Sex: M F

Marital Status: Divorced Widowed Married Single Social Security:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work Phone:_____Ext:_____

Primary Care Physician:_____Physician Phone:_____

Referring Physician:_____Physician Phone:_____

Emergency Contact:_____Phone:_____ Relationship To Patient:_____

IF PATIENT IS A MINOR, COMPLETE THE FOLLOWING INFORMATION

Mother's Name:_____Date of Birth:_____Social Security_____

Address (if different):_____City, State, Zip:_____

Father's Name:_____Date of Birth:_____Social Security_____

Address (if different):_____City, State, Zip:_____

Employer:_____

INSURANCE INFORMATION

Primary Policy Holder:_____Relationship to Patient:_____

Policy Holder's Date of Birth:_____Social Security:_____

Employer:_____

Insurance Name:_____Group No.: _____PolicyNo.:_____

Do you have a separate card for prescriptions? Yes No Pharmacy Choice:_____

Pharmacy Address:_____Pharmacy Phone:_____

COPAYS WILL BE COLLECTED AT TIME OF SERVICE FROM ALL PATIENTS OR PERSON ACCOMPANYING MINOR

Shoreline Allergy, P.C.

With my consent, Shoreline Allergy, P.C. may use and disclose Protected Health Information (PHI) about me or my child, to carry out Treatment, Payment and Healthcare Operations (TPO). Shoreline allergy P.C. may call my home or other designated locations and leave a message on voice mail or in person , in reference to any items that assist the practice carrying out TPO, such as reminder calls, insurance items and any call pertaining to my care, including laboratory results among others.

With my consent, Shoreline Allergy, P.C. may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. Shoreline Allergy, P.C. may call out my name or my child's name in the waiting room when it is my turn to be seen by the doctor or nurse for exam or allergy injections.

By signing this form, I am consenting to Shoreline Allergy P.C.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the proactive has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Shoreline Allergy, P.C. may decline to provide treatment to me or my child.

Print Patient's Name_____Date_____

Patient/Guardian
Signature_____

Assignment of Benefits:
I hereby assign al medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to:
Shoreline Allergy, P.C.
Frederick M. DeTorres, M.D.
This assignment will remain in effect until I invoke, in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Patient/Guardian
Signature_____

Shoreline Allergy, P.C.

Frederick M. DeTorres, M.D.
Wendi Grasman, PA-C
Timothy Pebbles, PA-C
Phone 231-799-8777
Fax 231-798-7423

PLEASE USE THIS FORM TO LIST ALL MEDICATIONS YOU ARE TAKING.

MEDICATION STRENGTH DOSAGE