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

PATIENT INFORMATION:

Patient Name:_____Age:_____DOB :_____Sex: M F

Address (local):_____City: _____St._____Zip Code:_____

Home Phone:_____ Cell Phone:_____ E-Mail:_____

Drivers License#:_____State:_____ **Approve method of contact?** HOME ☐ CELL☐ EMAIL☐ TEXT☐
(Check all that apply in order of preference 1-4)

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 Workers Compensation Insurance? ( ) YES ( ) NO

Insurance Co: _____Phone:_____

Mailing Address: _____

Name of Insured: _____Birthday:_____Social Security#:_____

Policy #_____Group#_____Employer:_____

Insured's 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:_____

Additional Information:

Referred by: * Doctor ( ) *Family ( ) *Friend ( ) Internet Search ( ) 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:_____