Allergy & Immunology Associates of New England

PATIENT REGISTRATION

Patient Information

Patient Name:____ A.K.A. _____________________
Address:____ State:__________ Zip: ________
Email:____ □ Opt out
Preferred Language:____ DOB:_______________________
Home Phone: ( ) _________________________ Cell: ( ) _______________________

Preferred Contact Method For Appointment Reminders: Phone Text Email

Gender: Male Female Race:____
Ethnicity: Hispanic Non-Hispanic Declined to Specify
Marital Status: Single Married Divorced Separated Widowed

Emergency Contact:____________________________ Relationship:________________________________
Home Phone:_________________________________ Cell:_______________________________________
Primary Care Physician: ______________________________ Referred by:___________________________
Pharmacy: ____

Insurance

Responsible Person:___________________________ Relationship to Patient: ________________________
Insurance Company: __________________________ Policy:____________________ Group: ____________
Subscriber: __________________________________Relationship to Patient: ________________________
Subscriber's DOB: ____________________________ Copay:___________________

Secondary Insurance: Yes No
Insurance Company:___________________________ Policy:____________________ Group: ____________
Subscriber: __________________________________ Relationship to Patient:_________________________
Subscriber's DOB: ____________________________ Copay:___________________

I request that payment of authorized Medicare/Other Insurance Company benefits be made on behalf of Allergy and Immunology Associates of New England, LLC. for any services furnished by its physicians or employees. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of any medical or any other information about me be released to my insurance company, the Social Security Administration and health care company, as applicable. I permit a copy of the authorization to be used in place of the original and request payment provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and the U.S.C. 3801-3812 provides penalties for withholding this information.)

Patient/Guardian Signature:____ Date:___________________