PATIENT (Minor) REGISTRATION FORM

Patient's Name: _____
(Legal Name) Last First Middle Maiden

Address:_____City_____State_____Zip_____

Date of Birth _____ **Age** _____ **Sex**_____ SS#: _____

In Case of Emergency Notify:_____
Name Relationship Phone#

TO WHOM MAY WE THANK FOR THIS REFERRAL;_____
Guarantor Is Parent Accompanying Patient

Guarantor: _____ Address:_____
(Please Print) - Last First
Home Phone: _____ Cell : _____ State: _____ Zip Code: _____

S.S.#: _____ Employer: _____ Wk#: _____

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PRIMARY HEALTH INSURANCE INFORMATION (Please have cards available to copy)
Name of Insurance_____**Name of Policyholder**_____

Policyholder's Date of Birth_____**Policyholder's SS#**_____

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SECONDARY HEALTH INSURANCE INFORMATION
Name of Insurance_____**Name of Policyholder** _____

Policyholder's Date of Birth_____**Policyholder's SS#**_____

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I hereby understand that all services provided by Asthma, Allergy, and Immunology, LLC (AA&I,LLC) Drs. B. Steele Rolston and Alisha I. Qureshi are due and payable at the time services are rendered. This office will file services to my child's insurance company. However, my insurance coverage is a contract between my insurance company and myself and I am ultimately responsible for the charges incurred on my child. It is understood that if payment for services is not received from my insurance company in 30 days, I will make payment to my account. It is further understood that I will pay any balance not paid by my insurance company.

_____

Guarantor Name (Print) Signature Date

I authorize the release of any medical records or financial information necessary to process my claims.

_____

Signature Date