PATIENT REGISTRATION FORM

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

Address:____________________City____________State________Zip__________

Home Phone ( )____________Wk( )____________Cell( )______________

Date of Birth __________ **Age** _______ **Sex**_______ **Marital Status** S M W D

SS#____________________ **Employer:**______________________**Wk#**__________

In Case of Emergency Notify:____
Name Relationship Phone#

TO WHOM MAY WE THANK FOR THIS REFERRAL:______________________

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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 insurance company. However, my insurance coverage is a contract between my insurance company and myself and I am ultimately responsible for the charges I incur. 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.

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Print Name Signature Date

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

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Signature Date