Dr. Helbing Allergy & Asthma Associates, Ltd.
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PATIENT REGISTRATION FORM

First Name: _____ **Last Name**:_____ **M.I:** _____ **Date of Birth:** _____/____/_____

Gender (Circle): Male Female **Race (Circle):** Asian Black/African American Caucasian Hispanic Other: _____

Address: _____ **City:** _____ **State:** ____ **ZIP:** _____

Mobile Phone: _____ **Work Phone:** _____ **Home Phone**:_____

Email Address: _____ Would you like to enroll in our portal? **Y N**

Social Security #: _____ **Marital Status (Circle):** Single Married Divorced Separated Widowed

Emergency Contact Name: _____ **Relationship to Patient:** _____ **Phone:** _____

Primary Care Doctor: _____ **Office Phone:** _____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____

Primary Insured Person: _____ **Relationship to Patient:** _____ **Date of Birth:** ___/___/____

Address, if other than above: _____

Insurance Company: _____ **Policy #:** _____ **Group #:** _____

Secondary Insurance, if any: _____ **Policy #:** _____ **Group #:**_____

How did you hear about us? Family/Friend Physician Online ZocDoc Other: _____

I authorize the release of medical information necessary to process this or any related claims to any insurance company. I permit a copy of this authorization and assignment to be used in place of original. I understand that I am responsible for all required referral authorizations and charges unless covered by prearranged health insurance plan.

If I did not arrange for proper referral authorization, I will be responsible for the charges. If the account must be turned over for collection, I will be responsible for costs and attorney fees associated with the collection of this account.

I hereby authorize Dr. Helbing Allergy & Asthma Assoc. LTD to perform skin tests, administer allergy injections, order and do any tests required for proper medical care, and render emergency treatment deemed necessary to myself or the above-named patient.

This office will be glad to process your insurance claim or provide you with the information needed to process your insurance claim.

SIGNATURE: _____ **DATE:** _____