

**ALLERGY & RHEUMATOLOGY ASSOCIATES, LLC  
PATIENT REGISTRATION FORM**

<b>Patient Name:</b>	<b>Race/Ethnicity:</b>	<b>Date of Birth:</b>
<b>Marital Status:</b> S    M    W    SEP    D	<b>Language:</b>	<b>Social Security #</b>
<b>Home Phone:</b>	<b>Cell Phone:</b>	<b>Work Phone:</b>
<b>Street Address:</b>	<b>City:</b>	<b>State:</b> <b>Zip Code:</b>
<b>Emergency Contact:</b>	<b>Phone#</b>	<b>Email:</b>

Primary Care Physician: \_\_\_\_\_ PHONE: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ PHONE: \_\_\_\_\_

**Insurance Information**

**Primary Insurance Carrier**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

**Secondary Insurance Information**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize Allergy & Rheumatology Associates, LLC to release my medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand that this authorization includes information with respect to HIV infections, AIDS, mental health, alcohol and substance abuse.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize Allergy & Rheumatology Associates, LLC to apply for benefits on my behalf for covered services rendered by her or by her order. I request that payment from my Insurance Company be made directly to Allergy & Rheumatology Associates, LLC. I understand that I am financially responsible for any balance not covered by my Insurance.

**AUTHORIZATION AND OTHER EXAMINATIONS:** It is my responsibility to contact my Primary Physician and/or my Insurance Company in order to provide a valid Referral at the time of the office visit. I hereby agree it will be my responsibility to provide Allergy & Rheumatology Associates, LLC with the most recent and complete examinations (primary physicians or specialist consults, surgery reports, invasive and non-invasive techniques of diagnostic, laboratories examination, radiographs, ultrasounds, MRI, CT scan, DEXA study and so) ordered here and in other medical office or hospital.

**COURTESY:** Please do not wear colognes, perfumes and/or creams at the time of your visit.

I have received a copy of the following:

""Initials \_\_\_\_\_ Allergy & Rheumatology Associates, LLC Notice of Privacy Practice

""Initials \_\_\_\_\_ Allergy & Rheumatology Associates, LLC Summary of the Florida Patient's Bill of Rights and Responsibilities

I certify that all of the information above is correct and permit a copy of this authorization to be used in place of the original.

**DATE:** \_\_\_\_\_ **PATIENT SIGNATURE:** \_\_\_\_\_