ALLERGY & RHEUMATOLOGY ASSOCIATES, LLC
PATIENT REGISTRATION FORM

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

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: