jerry lynn m.d. | allergy asthma immunology

PATIENT INFORMATION

PATIENT NAME:	BIRTH DATE:
ADDRESS:	GENDER: Male Female
OCCUPATION:	SSN:
EMPLOYER:	Cell Phone:
	Home Phone:
	Work Phone:

EMERGENCY CONTACT:

NAME:	
CELL/HOME PHONE:	Relation to patient:

PHYSICIAN INFORMATION:

PRIMARY CARE PHYSICIAN:	REFERRING PHYSICIAN:
TELEPHONE:	TELEPHONE:

INSURANCE INFORMATION:

PRIMARY INSURANCE:	SECONDARY INSURANCE:
SUBSCRIBER:	SUBSCRIBER:
SUBSCRIBER'S BIRTH DATE:	SUBSCRIBER'S BIRTH DATE:

PRESCRIPTION COVERAGE:	primary insurance	CVS Caremark	Medco
(check any applicable)	secondary insurance	ExpressScripts	Optum Rx

IF PATIENT IS 18 YEARS OLD OR YOUNGER:

MOTHER'S NAME:	FATHER'S NAME:
ADDRESS:	ADDRESS:

I authorize Allergy, Asthma, & Immunology Associates, P.C. to bill my insurance for all services that I receive and to release any medical information when necessary. I also understand that I am responsible for any charges that are not covered by my insurance.

Patient/Parent Signature: Date: