GENERAL INFORMATION

Please fill out and bring to your appointment

ALLERGYCARE OF CHATTANOOGA
1039 Executive Drive, Ste 102
Hixson, TN 37343

Phone 423.875.6162
E-mail info@allergycarechatt.com
Web www.allergycarechatt.com

PATIENT *(person coming to see the doctor. If patient is a child, please complete info on reverse side) (person coming to see the do

NAME _____ **DATE** _____ **SSN** _____ - ____ - _____ **DATE OF BIRTH** ____ / ____ / ____ **SEX M F**

MARITAL STATUS ❑ Married (spouse name_____) ❑ Widowed ❑ Single ❑ Divorced/Separated ❑ Partnered (partner name _____)

STREET _____ **EMPLOYER NAME** _____ **EMP. PHONE** _____

CITY _____ **STATE**_____ **ZIP**_____ **PRIMARY CARE PHYSICIAN (PCP):** **REFERRING PHYSICIAN:**

PHONE (indicate preference) ❑ home_____ **NAME** _____ **NAME** _____

❑ work _____ ❑ cell _____ **ADDRESS**_____ **ADDRESS** _____

E-MAIL ADDRESS _____ **PHONE** _____ **PHONE** _____

RESPONSIBLE PARTY (person responsible for paying bills; if same as patient, check here ■ and go to next section)

NAME _____ **SOC. SEC. NO.** _____ - ____ - _____ **DATE OF BIRTH** ____ / ____ / ___ **SEX M F**

MARITAL STATUS ❑ Married ❑ Widowed ❑ Single ❑ Divorced/Separated ❑ Partnered **RELATIONSHIP TO PATIENT** _____

STREET _____ **HOME PHONE** _____ **WORK PHONE** _____

CITY _____ **STATE**_____ **ZIP**_____ **E-MAIL ADDRESS** _____

RELEASE AUTHORIZATION & ACCEPTANCE OF FINANCIAL RESPONSIBILITY (Responsible Party must sign if patient is under 18)

AUTHORIZATION TO RELEASE INFORMATION TO (PCP) AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY: (Check ✔ for each)

❑ I authorize release of information to patient's primary care physician or other doctors. ❑ I understand and accept responsibility for all charges incurred.

❑ I have read Allergycare of Chattanooga's patient privacy statement. **SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**

(See reverse side)

_____

PRIMARY INSURED (person whose insurance covers the patient; check if same as patient ■ or Responsible Party ■ and go to next section)

NAME _____ **SOC. SEC. NO.** _____ - ____ - _____ **DATE OF BIRTH** ____ / ____ / ____ **SEX M F**

MARITAL STATUS ❑ Married ❑ Widowed ❑ Single ❑ Divorced/Separated ❑ Partnered **RELATIONSHIP TO PATIENT** _____

STREET _____ **HOME PHONE** _____ **WORK PHONE** _____

CITY _____ **STATE**_____ **ZIP**_____ **E-MAIL ADDRESS** _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME _____

EMPLOYER OF INSURED PERSON _____ **POLICY ID #** _____

BILLING/CLAIMS ADDRESS_____ **OFFICE VISIT CO-PAY AMOUNT $** _____

CITY _____ **STATE** ____ **ZIP** _____

AUTHORIZATION TO RELEASE INFORMATION AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

❑ I authorize release of information required to file a claim with my insurance company, and permit photocopy or other facsimile reproductions of this authorization to be used in place of the original. **Allergycare of Chattanooga does not assume any responsibility for denial of any or all parts of your claim by the insurance company**.

❑ I understand and accept responsibility for all charges incurred.

❑ I have read Allergycare of Chattanooga's patient privacy statement. (See reverse side)

SIGNATURE OF PRIMARY INSURED _____

Please complete other side of this form for secondary and tertiary insurance.

FOR BUSINESS OFFICE USE: Date recieved ____ / ____ / ____ Patient # _____ ❑ New ❑ Return Input by _____

SECONDARY INSURED (another person whose insurance covers the patient; check if same as patient ■ or Responsible Party ■ and go to next section)

NAME _____ **SOC. SEC. NO.** _____ - ____ - _____ **DATE OF BIRTH** ____ / ____ / ____ **SEX** M F

MARITAL STATUS ❑ Married ❑ Widowed ❑ Single ❑ Divorced/Separated ❑ Partnered **RELATIONSHIP TO PATIENT** _____

STREET _____ **HOME PHONE** _____ **WORK PHONE** _____

CITY _____ **STATE**_____ **ZIP**_____ **E-MAIL ADDRESS** _____

SECONDARY INSURANCE INFORMATION

INSURANCE CO. NAME _____

EMPLOYER OF INSURED PERSON _____ **POLICY ID #** _____

BILLING/CLAIMS ADDRESS_____ **OFFICE VISIT CO-PAY AMOUNT $** _____

CITY _____ **STATE** ____ **ZIP** _____

AUTHORIZATION TO RELEASE INFORMATION AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

❑ I authorize release of information required to file a claim with my insurance company, and permit photocopy or other facsimile reproductions of this authorization to be used in place of the original. **Allergycare of Chattanooga does not assume any responsibility for denial of any or all parts of your claim by the insurance company**.

❑ I understand and accept responsibility for all charges incurred.

❑ I have read Allergycare of Chattanooga's patient privacy statement. (See below)

SIGNATURE OF SECONDARY INSURED _____

❑ I have third/tertiary insurance.

Privacy Statement: Allergycare of Chattanooga

Allergycare of Chattanooga created this privacy policy to express our firm commitment to protecting the integrity of confidential information and the manner in which this information is used. The following discloses our information-gathering and dissemenation practices for our organization.

It is the policy of Allergycare of Chatanooga not to share patient-identifiable information, received by Allergycare of Chatanooga in the course of delivering care, with outside parties without prior approval from the owner of that information. Furthermore, we will take appropriate measures within our organization to ensure employees or other third parties protect information we work with in the course of our business activities. Allergycare of Chattanooga abides by all local, state, and federal regulations regarding the protection of private information (for example, HIPAA, the federal Health Information Portability and Accountability Act of 1996). From time to time Allergycare of Chattanooga does undertake research and analysis of non-patient-identifiable information (that which cannot be linked to an individual). If specific research requires patient-identifiable information, Allergycare of Chattanooga will seek written authorization from patients for such use.

Antihistamine Reminder

Please remember!! Do not take antihistamines* (see list below) for 3 days before your appointment, as this may affect our ability to do skin testing. You may continue to take asthma medications.

* Optimine®
Cardec®
Zyrtec®
Periactin®
Polaramine®
Dexchlor ER®
Allegra®
Claritin®
Phenergan®
Pelamine®
Triplen®
Dimetapp Allergy®
NasahistB®
Chlor-Trimeton®
Tavis-1®
Benadryl®