Allergy and Asthma of Illinois, SC
Stephen J. Smart, MD
Penelope A. Ewbank, MD

OFFICE USE ONLY
No change patient information
Date: _____ Initial: _____
Date: _____ Initial: _____
Date: _____ Initial: _____

Date_____

PATIENT INFORMATION QUESTIONNAIRE

Last Name_____ First Name_____ Middle Initial_____
Address_____ City_____ State_____ Zip Code_____
Gender ☐ Male ☐ Female / ☐ Married ☐ Single Home Phone Number:_____/_____
Date of birth _____/_____/_____ Work Phone Number_____/_____
Social Security Number_____/_____/_____ Cell Phone Number_____/_____
Email Address_____
Employer_____ Employer Address_____
Family Doctor_____ Address of Family Doctor_____

CUSTODIAL PARENT / GUARDIAN (if patient is a minor)

Last Name_____ First Name_____ Middle Initial_____
Address_____ City_____ State_____ Zip Code_____
Gender ☐ Male ☐ Female / ☐ Married ☐ Single Home Phone Number:_____/_____
Date of birth _____/_____/_____ Work Phone Number_____/_____
Social Security Number_____/_____/_____ Cell Phone Number_____/_____
Email Address_____
Employer_____ Employer Address_____
Family Doctor_____ Address of Family Doctor_____

PRIMARY INSURANCE INFORMATION

Company Name_____Address_____
Group Number_____ Policy/ID Number_____
Policy Holder Name_____Policy Holder Date of Birth_____/_____/_____
Policy Holder Address_____
City_____ State_____ Zip Code_____
Policy Holder SSN:_____/_____/_____
Place of Employment_____
Patient's relationship to card holder_____

SECONDARY INSURANCE INFORMATION

Company Name_____Address_____
Group Number_____ Policy/ID Number_____
Policy Holder Name_____Policy Holder Date of Birth_____/_____/_____
Policy Holder Address_____
City_____ State_____ Zip Code_____
Policy Holder SSN:_____/_____/_____
Place of Employment_____
Patient's relationship to card holder_____

(PLEASE TURN FORM OVER AND COMPLETE OTHER SIDE)

RELATIVE INFORMATION

Nearest relative (not living with you)_____

Home Phone_____/_____ Work Phone_____/_____

Whom may we contact in case of any emergency?_____

How did you hear about our practice?_____

Name of referring physician_____

RELEASE OF INFORMATON STATEMENT

I authorize Allergy & Asthma of Illinois, SC to release all necessary medical records or other information about me or my medical benefits claims to my insurance companies or their intermediaries or carriers. I permit a copy of this authorization to be used in place of the original.

_____

Signature of Patient or Guardian of Patient Date

FINANCIAL AGREEMENT

I acknowledge that financial responsibility for bill payment rests solely with the patient or his/her family regardless of any insurance coverage. I further acknowledge that medical benefits are contracted solely with the insured (i.e. patient/family) and not this office, unless a specific contract has been assigned between Allergy & Asthma of Illinois, SC and my insurance carrier or health plan. In the event that I fail to make timely payment in full, or if I fail to make a reasonable payment arrangement and my account becomes past due, I shall be liable for and I agree to pay, all collection agency fees (not to exceed 33.3%), reasonable attorney's fees and court costs.

_____

Signature of Patient or Guardian of Patient (must be 18 years or older to sign) Date

RELEASE OF INFORMATION VIA FAX

I release Allergy & Asthma of Illinois, SC to fax any of my personal health information to any other Health Care Provider that either Dr. Stephen Smart or Dr. Penelope Ewbank deems necessary for my continuing health care.

Permission Granted YES or NO

EMAIL AND TEXT COMMUNICATION WITH PATIENT

Permission Granted YES or NO

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Signature of Patient or Guardian of Patient Date