DFW Asthma & Allergy Center

New Patient Paperwork

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Last Name _____ First Name _____ MI _____

Street Address _____ APT # _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Date of Birth _____

Social Security _____ Preferred Pharmacy Name _____

Preferred Pharmacy Address _____

Emergency Contact Name _____ Emergency Contact Number _____

PCP Name _____ PCP Phone Number _____

Ethnicity: □ White/Caucasian □ Black/African American □ Hispanic/Latino □ Asian □ Native Hawaiian/Pacific Islander □ Other

Race: □ Hispanic/Latino □ Not Hispanic/Latino □ Patient Declines to provide

Primary Insurance Name, Phone, Address _____

Name of Insured _____ DOB _____ Relationship _____

Insured's ID Number _____ Group Number _____ Insurance Type: HMO PPO POS PO INDEM

Secondary Insurance Name, Phone, Address _____

Name of Insured _____ DOB _____ Relationship _____

Insured's ID Number _____ Group Number _____ Insurance Type: HMO PPO POS PO INDEM

I hereby authorize payment of medical benefits billed to my insurance by ***DFW Asthma & Allergy Center***. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered. I authorize the release of any medical information necessary to process an insurance claim and also request payment of government benefits either to myself or to the party who accepts assignment below

Signature of Patient or Guardian (if patient is under 18*) _____ Date _____

*IF PATIENT UNDER AGE 18, Dr. Ghazi and staff have my permission to exam and treat

How did you find us: Google ZocDoc Yelp Other _____