ALLERGY & ASTHMA CARE OF NEW YORK

Clifford W. Bassett, M.D.
Ujwala Kaza, M.D.

Patient's Name: _____ Date Of Birth: _____ Age: _____

Street Address: _____ Telephone (Home): _____

City: _____ State: _____ Zip: _____ Telephone (Work): _____

Social Security Number: _____ Cell Phone / Pager: _____

Occupation: _____ Email Address: _____

Patients Employer / Address: _____

Referring Physician / Address: _____

Additional Physician Reports To: _____ _____

SEX: ☐ Male ☐ Female **MARITAL STATUS:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Chief Complaint: _____ Other Referral Sources: _____

Emergency Contact: _____ _____

PRIMARY INSURANCE
(copy of insurance card is required)

Name of Insurance Company: _____

Address: _____

ID or Policy Number: _____ Group #: _____

Effective Date of Insurance: _____

Who is Subscriber: (check one) ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

If Subscriber Is Other Than Self - Complete The Following:

Subscribers Name: _____
(check one) ☐ Male ☐ Female

Address: _____

Date Of Birth: _____

Social Security Number: _____

SECONDARY INSURANCE
(copy of insurance card is required)

Name of Insurance Company: _____

Address: _____

ID or Policy Number: _____ Group #: _____

Effective Date of Insurance: _____

Who is Subscriber: (check one) ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

If Subscriber Is Other Than Self - Complete The Following:

Subscribers Name: _____
(check one) ☐ Male ☐ Female

Address: _____

Date Of Birth: _____

Social Security Number: _____

AUTHORIZATION INFORMATION
(Assignment of Benefits)

I herby assign to _____ any insurance or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arraignment, payment to the practice will be made by any insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at he time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except where prohibited by contract). I also understand that in the event that services rendered are not covered under by "insurance", I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and / or to remake payment, in full, for the services rendered to me (depending upon the assignment) at this time.

Signature: _____ Date: _____

FOR RELEASE OF INFORMATION

I authorize the release of any medical information or other information as is necessary to process this claim based upon the :HIPPA Notice of Privacy Practices". Information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary.

Signature: _____ Date: _____