The Asthma & Allergy Center

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Insurance Information

(Please Print)

Patient Name _____ Date _____
Last First Initial

Primary Insurance_____ Policy Date/Effective Date _____

Insurance Address_____ Member Number/Insured Party ID _____

_____ Group Number _____

If BCBS, is it out of state? ☐Yes ☐No Office Visit Copay $ _____ Specialty Copay $_____

Subscriber's Name_____ Subscriber's Date of Birth _____

Subscriber's Address (if different from Patient) _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

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Do you have a second insurance carrier? ☐Yes ☐No If yes, please complete:

Secondary Insurance _____ Policy Date/Effective Date _____

Address _____ Member Number/Insured Party ID _____

_____ Group Number _____

Subscriber's Name_____ Subscriber's Date of Birth _____

Subscriber's Address (if different from Patient) _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

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Do you have a third insurance carrier? ☐Yes ☐No If yes, please complete:

Third Insurance _____ Subscriber Name _____

********** **Please complete if the patient is under 19 years of age** **********

Name of Father _____ Name of Mother _____

Address _____ Address _____

_____ _____

Father's Date of Birth _____ Mother's Date of Birth _____

Father's Daytime phone _____ Mother's Daytime phone _____

Father's SS# _____ Mother's SS# _____

Father's Employer _____ Mother's Employer _____

Once the insurance has paid, to whom should the statement be sent? ☐Father ☐Mother

☐ Other (Name): _____ Relationship to Patient _____

Address _____

Are the mother and father of the child divorced? ☐Yes ☐No

Can both the mother and father have access to the child's medical records? ☐Yes ☐No*

*If no, please provide the court order stating the contrary.

Do mother and father both wish to receive copies of the office visit notes? ☐Yes ☐No