Patient Registration
Fishman Allergy and Asthma

Print Form

Patient #
Referring Physician Patient Visit #

Patient's Name First	Middle	Last	Date of Birth

Home Address Street Address	City	State	Zip Code

Occupation	SS#	Sex	Marital Status	Home Phone

Employer	Employer Address	Employer Phone

Spouse (or partner) Name	Spouse (or partner) Employer	Spouse (or partner) Employer Phone

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Whether or not your insurance company pays in full, a portion or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, check, Money Order, Visa or MasterCard.

I agree to promptly pay all charges when billed for medial services rendered and accept legal responsibility for any and all charges for the patient named above x_____

SEND BILL TO	First Name	Last Name	Relationship to Patient
	Home Address	City	State
	Employer	Work Phone	Home Phone

PRIMARY INSURANCE	Insurance Company Name	ID or Policy #	Group / Code
	Insurance Company Address	Policy Holder SS#	Date Effective
	Policy Holder's Name	Home Phone	Relationship
	Policy Holder's Address	Work Phone	Policy Holder's Date of Birth

SECONDARY INSURANCE	Insurance Company Name	ID or Policy #	Group / Code
	Insurance Company Address	Policy Holder SS#	Date Effective
	Policy Holder's Name	Home Phone	Relationship
	Policy Holder's Address	Work Phone	Policy Holder's Date of Birth

PATIENT AUTHORIZATION **OPTION: OPT OUT – No Referral_____**

I _____, hereby authorize Dr. Henry J. Fishman to apply for benefits on my behalf for services rendered. I request payment be made directly to Dr. Henry J. Fishman.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named insurance company. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time in writing.

_____ _____
Signature of Responsible Party Date