	Adult Patient Registration *Confidential Patient Information*	Date - -
Patient Name		Birthdate - -
Home Address		Home # - -
City/State/Zip		Work/Cell # - -
Occupation	Patient's Employer/Employer's Address	Employer's # - -
SSN - -	Driver's License #/State	
Spouse's Name		Birthdate - -
Home Address		Home # - -
City/State/Zip		Work/Cell # - -
Occupation	Spouse's Employer/Employer's Address	Employer's # - -
SSN - -	Driver's License #/State	
	Person To Notify In Case Of Emergency <u>(not living w/you)</u>	
Name		Contact # - -
Home Address		
City/State/Zip		
How Did You Hear About This Office?		Pharmacy Name
Family/Primary Physician		Pharmacy Location
Known Allergies		Pharmacy #
Insurance Holder		- -

I authorize all physicians employed by Asthma Allergy Centre to furnish my insurance company with all information requested concerning my claim. I assign to Asthma Allergy Centre all benefits from my insurance policy or any other policies covering my condition. I am financially responsible to Asthma Allergy Centre for all charges not paid by my insurers. I agree to pay all reasonable court costs and attorney fees incurred by Asthma Allergy Centre in collecting unpaid balances owing to them. I am aware that unpaid balances 90 days after billing will result in a service charge of $5.00 per month until all portions of the balance 90 days and older have been paid. **RESPONSIBLE PARTY SIGNATURE:** **Date:**