TEXAS ALLERGY
Medical Center • Northwest Houston • Southwest Houston
2424 W. Holcombe, Ste 104, Houston, TX 77030 • 800 Peakwood, Ste 6H, Houston, TX 77090 • 8282 Bellaire, Ste 162, Houston, TX 77036
Phone: (281) 886-7440 • Fax: (281) 929-0086 • Email: info@texasallergygroup.com • Website: www.texasallergygroup.com

PATIENT INFORMATION:

Patient Name:______________________ Age:________ Birth Date:____________ Sex: M F

Social Security#:__________________ Drivers License#:__________________ State:______

Address (local):__________________ City:____________ St.______ Zip Code:______

Home Phone:____________ Cell Phone:____________ Email: ____________________

Employer:__________________ Occupation:____________ Phone:____________

Address (out of area):__________________ City:____________ St.______ Zip Code:______

Phone (out of area):__________________ Marital Status: ( ) Single ( ) Married ( ) Other

Spouse information: ( ) OR Emergency Contact ( ) (if not married, please give emergency contact name & phone information)

Name:______________________ Employer:______________________

Occupation:______________________ Phone:______________________

PRIMARY INSURANCE INFORMATION: Is this a Workers Compensation Insurance? ( ) YES ( ) NO

Insurance Co:______________________ Phone :______________________

Mailing Address:____

Name of Insured:__________________ Birth Date:____________ Social Security#:______________

Policy #__________________ Group#____________ Employer:______________

Insured's Relationship to Patient:______________________

Secondary Insurance Information: Do you have other insurance coverage? ( )YES ( ) NO

Insurance Co:______________________ Phone :______________________

Mailing Address:____

Name of Insured:__________________ Birth Date:____________ Relationship to Patient:______________

Policy #__________________ Group#____________ Employer:______________

Other Misc. information:

Referred by: * Doctor ( ) *Family ( ) *Friend ( ) Phone Book ( ) Insurance Book ( ) Other ( )__________

*Please give name & address:____

Family Physician (PCP)______________________ Phone:______________________

Do you have other family members who are patients in our office?______________ Relationship______________

FINANCIAL RESPONSIBILITY, ASSIGMENT OF BENEFITS, AND RELEASE OF PROTECTED HEALTH INFORMATION

- I herby agree to pay Texas Allergy | Texas Allergy Group, PLLC for all charges (to include co-pays, deductible and co-insurance amounts) at the time of service. I understand that although the office may accept assignment of insurance benefits, the charges ultimately are my responsibility. I realize that if a balance is due necessitating the use of a collection agency, I agree to pay all collection costs, including attorney fees.
- I authorize Texas Allergy | Texas Allergy Group, PLLC to file insurance claims on my behalf to the company (ies) with which I have coverage to include the Social Security Administration. I authorize payment to be made to Texas Allergy | Texas Allergy Group, PLLC for services rendered to me.
- I consent to the release of protected health information which may be necessary to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.
- I acknowledge that I have received a copy of Texas Allergy | Texas Allergy Group, PLLC Health Insurance Portability & Accountability Act (HIPAA) Notice of Privacy Practices.

Patient Signature:______________________ **Date:**______________