PATIENT INFORMATION FORM

Date_____

PLEASE COMPLETE ALL INFORMATION FULLY

Patient Name (Last Name, First, Middle Initial)		Sex	Date of Birth		Age
Address	City		State	Zip	Home Phone
Occupation	Employer			Cell Phone	Work Phone
Spouse's Name	Employer			Cell Phone	Work Phone

☐ BCBS ☐ MEDICARE **(MUST complete reverse)** ☐ MEDICAID/FIRSTGUARD ☐ OTHER INSURER _____ (Name)

RELATIONSHIP TO POLICY HOLDER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

POLICY HOLDER'S NAME	POLICY HOLDER'S DATE OF BIRTH	ID#	GROUP#

☐ NO INSURANCE PLEASE DESCRIBE METHOD OF PAYMENT

☐ **CHECK HERE IF YOU HAVE BEEN SCREENED FOR ASTHMA/ALLERGIES BY TOPEKA ALLERGY AND ASTHMA CLINIC**

IF PATIENT IS A CHILD OR DEPENDENT PLEASE COMPLETE THIS SECTION

DOES HE/SHE: ☐ Live with both parents ☐ Live with mother ☐ Live with father ☐ Other _____

Father's Name (Last, First, Initial)			Mother's Name (Last, First, Initial)		
Address		Date of Birth	Address		Date of Birth
City	State	Zip	City	State	Zip
Occupation	Home Phone		Occupation	Home Phone	
Employer	Work Phone		Employer	Work Phone	
	Cell Phone			Cell Phone	

PATIENT CONSENT AGREEMENT- Provider may condition treatment if not signed

I HAVE READ AND UNDERSTAND THE TERMS OUTLINED IN THE *CLINIC PROCEDURES AND POLICIES.* I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY INSURANCE. I REQUEST PAYMENT OF MEDICAL BENEFITS TO TOPEKA ALLERGY AND ASTHMA CLIINIC FOR SERVICES FURNISHED TO ME. I ALSO AUTHORIZE YOU TO RELEASE TO MY INSURANCE COMPANY INFORMATION CONCERNING HEALTH CARE, ADVICE, TREATMENT OR SUPPLIES PROVIDED TO ME FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS OF BENEFIT. A COMPLETE DESCRIPTION OF USES FOR THIS AUTHORIZATION IS AVAILABLE IN OUR PRACTICE'S *PRIVACY NOTICE*, WHICH IS AVAILABLE TO THE PATIENT/RESPONSIBLE PARTY UPON REQUEST.

SIGNATURE _____ **DATE** _____

Nearest friend or relative not living with you		Relationship		Phone
☐ SELF- REFERRED (If so, how did you decide to choose our office?)		☐ PHYSICIAN REFERRED (please list first and last name)		
Family Doctor	City	Pharmacy Preference	City	Phone

MEDICARE REQUIRES COMPLETION OF THE FOLLOWING:

MEDICARE LIFETIME SIGNATURE ON FILE

I request payment of authorized Medicare benefits to me or on my behalf to Topeka Allergy and Asthma Clinic for any service furnished to me by the physician(s). I authorize any holder of medical information to release to the Health Care financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

Patient signature	Date

MEDGAP AUTHORIZATION

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Topeka Allergy and Asthma Clinic for any services furnished me by the physician. I authorize any holder of medical information about me to release to _____(name of secondary insurance) any information about me to determine these benefits or the benefits payable for related services.

Patient signature	Date

OTHER INSURANCE

Insurance or Plan Name
Policy or Group Number
Insured's Name
Insured's Date of Birth
If Insured is Employed, Please List Employer

MEDICARE SECONDARY PAYER QUESTIONAIRE
(COMPLETE FOR ALL MEDICARE PATIENTS)

YES NO

1. Is the patient a Veteran?
   a. Did the VA refer you here for treatment?
   b. Does the patient have a VA "fee basis ID card"?

2. Do you have a Federal Black Lung card?

3. Is this medical condition due to an accident of any kind?
   If yes was it: Work related Auto
   Injured in own home Other

4. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member?

IS THE PATIENT ENTITLED TO MEDICARE BASED ON:

☐ Age (65 & over)
☐ Disability
☐ ESRD (End-Stage Renal Disease)