



3619 Paesano's Parkway Suite 112  
San Antonio, Texas 78231  
(210)455-2000

**PATIENT INFORMATION**

Date: \_\_\_\_\_ Primary Physician: \_\_\_\_\_ Email: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Maiden Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

SS#: \_\_\_\_\_ Martial Status:  S  M  OTHER

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

SS#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_**

**\*\*\*\*INSURANCE INFORMATION\*\*\*\***

**Name of Primary Insurance:** \_\_\_\_\_ Co-Pay Amount \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insurance Claims Address: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_

Insured Last Name: \_\_\_\_\_ Insured First Name: \_\_\_\_\_

Policyholder SSN# \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insured Address (if different from patient's): \_\_\_\_\_

Insured Employer: \_\_\_\_\_

**Name of Secondary Insurance:** \_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insurance Claims Address: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_

Insured Last Name: \_\_\_\_\_ Insured First Name: \_\_\_\_\_

Policyholder SSN# \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insured Address (if different from patient's): \_\_\_\_\_

Insured Employer: \_\_\_\_\_

**PAYMENT POLICY:**

**I understand that I am ultimately responsible for any balance that accumulates and agree to pay any balance due after insurance has paid or responded.**

**AUTHORIZATION OF PAYMENT: I hereby authorize Allergy Institute of San Antonio to release medical information concerning my examination and/or treatment for insurance purposes and to receive direct payment for medical benefits payable to me for services rendered.**

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_