Princeton Allergy & Asthma Associates, P.A.

PATIENT INFORMATION (Please use BLACK PEN Only)

Name _____ **Sex** M F **Date of Birth** ____/____/____

Street Address_____ **City**_____ **State**_____ **Zip**_____

Primary Phone (_____) _____ Home____ Cell____ Ok to leave extended message? Yes No
(cell # must be parent's if patient is under 18)

Secondary Phone (_____) _____ Home____ Cell____ Ok to leave extended message? Yes No

Work Phone (_____) _____ Ext_____ Ok to leave brief message? Yes No Extended message? Yes No
(Princeton Allergy & Asthma Associates, P.A. will leave a brief message on any home or cell phone number listed)

Marital Status? Single Married Divorced Widow **SS #** _____ **Email Address**_____

Race _____ **Ethnicity** Hispanic Not Hispanic N/A **Preferred Language** _____

Referring Physician _____ **Address** _____ **Phone (**____) _____

Primary Care Physician _____ **Address** _____**Phone (**____) _____

Emergency Contact we may release medical information to _____**Relationship** _____**Phone** (____) _____

How did you hear about us? Doctor Friend Insurance Company Internet Search Yellow Pages Family Previous Patient

RESPONSIBLE PARTY INFORMATION (for children under 18, parent must be present for appointment) .

Name _____ **Date of Birth** ____/____/____ **SS#**_____ **Sex** M F

Street Address (if different from patient)_____ **City**_____ **State**_____ **Zip**_____

Home Phone (____)_____ **Cell Phone** (____)_____ **Work Phone** (____)_____Ext____

Relationship Parent Legal Guardian Other _____ **Marital Status**? Single Married Divorced Widow

INSURANCE INFORMATION .

Primary Insurance _____ **ID#**_____ **Group #**_____ **Effective Date**___/___/___

Subscriber _____ **Date of Birth** ___/___/___ **Sex** M F **Relationship to insured** Self Spouse Child Other____

Street Address (if different from patient)_____ **City**_____ **State**_____ **Zip**_____

Home Phone (____)_____ **Cell Phone** (____)_____ **Work Phone** (____)_____Ext____

Secondary Insurance _____ **ID#**_____ **Group #**_____ **Effective Date**___/___/___

Subscriber _____ **Date of Birth** ___/___/___ **Sex** M F **Relationship to insured** Self Spouse Child Other____

Street Address (if different from patient)_____ **City**_____ **State**_____ **Zip**_____

Home Phone (____)_____ **Cell Phone** (____)_____ **Work Phone** (____)_____Ext____

Any Other Insurance Yes No If Yes, Please list _____

I have been offered a copy of Princeton Allergy & Asthma Associates P.A. Notice Regarding Privacy of Personal Health Information. I authorize the release of any medical or other information necessary in the processing of my claims. I also request the release of payment be made directly to Princeton Allergy & Asthma Associates, P.A.

Signature_____ **Date** ____/____/____

CLINICAL RESEARCH .

PAAA physicians are involved in clinical research. PAAA may provide you with information regarding clinical studies that you may want to participate in. Most of the clinical research studies are conducted by PAAA's affiliate organization, Princeton Center for Clinical Research. Any use or disclosure of your medical information for research purposes will maintain the privacy of your medical information and you will not be personally identified.

Would you like information on the benefits of participation in Clinical Research? **Yes No** (If YES, please read the following statement and sign below)

I authorize the release of my medical information to Princeton Center for Clinical Research. I understand that this authorization has no expiration and I may revoke this authorization at any time, giving written notice to the health care provider.

Signature_____ **Date** ____/____/____ 6/01/17