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**__________

Cell Phone (_____) ____________________________________ Add'l Phone (_____) ______________________ H / C

(cell # must be parent's if patient is under 18)

Marital Status? Single Married Divorced Widow **SS #** _____________________________________

Email Address____

Emergency Contact we may release medical information to:

Name: ____ **Relationship** _______________ **Phone** (________) _________________

RESPONSIBLE PARTY INFORMATION **(for children under 18. Parent must be present for appointment)**

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

SS#_____________________________ **Relationship:** Parent Legal Guardian Other ______ **Marital Status**? S M D W

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

Cell Phone (_____) ______________________ **Add'l Phone** (_____) ___________________ **Work Phone** (____) _______________

INSURANCE INFORMATION **Name of Insurance:** ____

Subscriber ID#: ____ **Group #:** _____________________________________

Subscriber Name: ____ **Subscriber DOB:** ______________ **Subs. Sex: M F**

Second Insurance? If yes, Insurance Name and ID #: ____

Subscriber Name: _______________________________________ **Subscriber DOB:** ___________________ **Subs. Sex: M F**

HIPAA Disclosure Information of Protected Health Information

Name: ____ **Race** ___________________ **Ethnicity** Hispanic Not Hispanic N/A

This authorization is given by: _____ **The Patient** ______**Parent/Guardian** ___________________________

_____ I consent to the electronic patient data exchange between PAAA and my other medical providers.

The physicians/practice may disclose to:

____ **Any medical provider/facility** (Sending medical records will still require a written request with a signature)

Referring Physician ____________________________ **Address** __________________________________**Phone** (____) _____________

Primary Care Physician _________________________**Address** __________________________________**Phone** (___) ______________

____ **Spouse**______________________________ ____ **Parent**_______________________________

Print Name Print Name

____ **Other**____

Print Name Relationship

We offer helpful administrative information by regular text messaging and email (**ie appointment reminder, refill info**). There is some level of risk that information on your phone/computer could be read by someone besides you. Please indicate preferences below.

EMAIL: YES – You may communicate with me by **email**. My email address is ____.

Circle one I will notify you right away if my email address changes

NO - Please do NOT communicate with me by regular email

CELL PHONE: YES – You may communicate with me by **text message**. My cell phone # is _____________________________.

Circle one I will notify you right away if my cell phone number changes

NO - Please do not communicate with me by regular text message. *We confirm most appointments via text.

This authorization in effect until revoked in writing.

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** ____/____/____