



ALLERGY ASTHMA CARE, P.C.

3125 Willowcreek Rd
Portage, IN 46368
(219) 762-3055

2802 Leonard Drive
Valparaiso, IN 46383
(219) 531-5855

5521 W. Lincoln Hwy
Suite 100
Crown Point, IN 46307
(219) 756-6100

Patient Information:

Name _____ DOB: ___ / ___ / ___ Age ___ Sex: M ___ F ___

Address _____ City _____ State _____ Zip _____

Social Security No _____ Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____ Email _____

Insurance Information:

Primary Insurance _____ Policy ID No _____

Address _____ Group No _____ Effective Date ___ / ___ / ___

Policy Holder's Name _____ DOB ___ / ___ / ___ Social Security No _____

Secondary Insurance _____ Policy ID No _____

Address _____ Group No _____ Effective Date ___ / ___ / ___

Policy Holder's Name _____ DOB ___ / ___ / ___ Social Security No _____

Responsible Party:

Name _____ DOB ___ / ___ / ___ Social Security No _____

Address _____ Home No _____ Cell No _____

Emergency Contact

Name _____ Relationship to Patient _____ Phone _____

By my signature below I:

- (A) Authorize payment directly to Allergy Asthma Care, P.C., for the surgical and/or medical benefits, if any otherwise payable to me for the services; and
- (B) Authorize to release information acquired in the course of my examination or treatment to referral physician or your insurance company.
- (C) I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Signature _____ Date ___ / ___ / ___