# CAROLINA ALLERGY & ASTHMA CONSULTANTS, P.A.

## PATIENT REGISTRATION FORM

Updated: ___________________
(Date)

**Patient's Name:** __________________________________________________ Age: ______ DOB: _______/_____/_______
(Last) (First) (M.)
Telephone No.: (____) __________________ Mobile No.: ________________ E-Mail: ________________________________
Home Address: __________________________________________________________________________________________
(Street) (City) (State) (Zip Code)
Billing Address (if different): ____________________________________________________________________________
(Street) (City) (State) (Zip Code)
Social Security No.: _________________________________ Male Female Marital Status: M S W D Child
Employer/School: _______________________________________________________________________________________
(Name) (Address) (City) (State) (Zip Code)
Employer Tel. No.: _____________________________ Occupation ________________________________________________
Primary Care Physician & Group: ____________________________________________________________________________
(Name) (Group Name)
______________________________________________________________________________________________________
(Address) (City) (State) (Zip Code) (Tel. No.) (Fax No.)
Referring Physician: _____________________________________________________________________________________
(Name) (Address) (Tel. No.) (Fax No.)
Pharmacy: _____________________________________________________________________________________________
(Name) (Address) (Tel. No.)

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**Name:** _______________________________________________________ Relationship: _________________________________
(Last) (First) (M.)
Address: _______________________________________________________________________________________________
( Street) (City) (State) (Zip Code)
Home Tel. No.: ________________________ Work Tel.: ______________________ Mobile: ___________________________
DOB: ____/____/____ Age ____ Soc. Sec. #: ________________________ Male Female
Employer: ______________________________________________________________________________________________
(Name) (Address) (City) (State) (Zip Code)

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**Emergency Contact:** _________________________________________ Relationship:__________________________________
Home Tel: _______________________ Work Tel.: _____________________ Mobile: ____________________________________
Special Instructions: ______________________________________________________________________________________

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**Primary Insurance:** __________________________________________ Tel. No.: _____________________________________
Policy Holder's Name: ___________________________________ Relationship: _________________ DOB: ________________
Policy Holder's Employer: _____________________________________ Tel. No.: _____________________________________
Soc. Sec. #: _______________________Policy ID No.: _________ Plan No.: ____________ Group No.: ___________________

**Secondary Insurance:** ________________________________________ Tel. No.: _____________________________________
Policy Holder's Name: _____________________________________Relationship: _________________ DOB: _______________
Policy Holder's Employer: ______________________________________ Tel. No.: _____________________________________
Soc. Sec. #: _______________________ Policy ID No.: ____________ Plan No.: ______________ Group No.: ______________

I hereby authorize Carolina Allergy & Asthma Consultants, P.A. to furnish information to my insurance carriers and assign payment to the physicians for medical services rendered to myself or my dependent.

***I Do Do Not authorize CAAC to leave medical appointment information on my voice machine.***

________________________________________________ ______________________________________
Signature of Patient/Responsible Party Date