

Date: _____

Robert E. Younger III, M.D.
Michael C. Hollie, M.D.
Russell L. Walker, M.D.
Curt Chaffin, M.D.
Linda J. Kim, M.D.

The Allergy and Asthma Group
ADULT PATIENT INFORMATION

REFERRED BY _____ PRIMARY CARE PHYSICIAN _____ Phone: _____

PATIENT _____ PHONE (_____) _____
First Middle Last Preferred Name Area Code

Age _____ Birthdate _____ Male Female S.S.# _____

ADDRESS _____
Street Name or PO Box

_____ City State Zip Code

MARITAL STATUS Married Single Other

EMPLOYER _____ BUSINESS PHONE (_____) _____
Area Code

ADDRESS _____
Street City State Zip Code

SPOUSE'S NAME _____ S. S. # _____
Birthdate

EMPLOYER _____ BUSINESS PHONE (_____) _____
Area Code

ADDRESS _____
Street City State Zip Code

EMERGENCY INFORMATION: Friend or relative at different address: _____
Name
Address Phone (_____) _____
Area Code

INSURANCE INFORMATION

1. _____
Name of Insurance Insured's Name

_____ Policy or I.D. Group #

2. _____
Name of Insurance Insured's Name

_____ Policy or I.D. Group #

Medicare # _____ GA/TN Medicaid # _____

YELLOW/GREEN CARD

Payment is due when services are rendered!

1. AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE ASTHMA, IMMUNOLOGY & ALLERGY ASSOCIATES, P.C., TO RELEASE ANY SOCIAL AND MEDICAL INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT FOR THE PURPOSE OF FILING FOR INSURANCE BENEFITS AND OTHER FINANCIAL COVERAGE.

Date _____ Signature of Patient _____

2. AUTHORIZATION TO PAY: I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO ASTHMA, IMMUNOLOGY & ALLERGY ASSOCIATES, P.C. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS ASSIGNMENT AND, SHOULD THE ACCOUNT BE REFERRED TO A COLLECTION AGENCY, I AGREE TO PAY REASONABLE ATTORNEY FEES AND COLLECTION EXPENSES.

Date: _____ Signed by Insured Person _____

IN ORDER FOR ALLERGY TESTING TO BE MOST ACCURATE, PLEASE DO NOT TAKE ANY ANTIHISTAMINES FOR AT LEAST 5 DAYS BEFORE YOUR APPOINTMENT.