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

CHILD PATIENT INFORMATION

REFERRED BY ________________________ PRIMARY CARE PHYSICIAN ____________________________ Phone ______________

PATIENT ____
First Middle Last Preferred Name

Age _______ Birthdate ________________ ☐ Male ☐ Female S. S. # ______________________ Phone (_____)____________
Area Code

Address ____
Street Name or PO Box

____
City State Zip Code

FATHER'S NAME ____
First Middle Last SS# Birthdate

Address ____ Phone (_____)____________________________
Street Name or PO Box City State Zip Code Area Code

Employer ____ Business Phone (______)______________________
Address Area Code

MOTHER'S NAME ____
First Middle Last SS# Birthdate

Address ____ Phone (_____)____________________________
Street Name or PO Box City State Zip Code Area Code

Employer ____ Business Phone (______)______________________
Address Area Code

EMERGENCY INFORMATION: Friend or relative at different address: ______________________________________
Name
____ Phone (_______) ______________________
Address 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!

Our office policy states that the parent/legal guardian requesting treatment for the child is responsible for all fees of services rendered.

1. AUTHORIZATION TO TREAT AND RELEASE OF INFORMATION: I hereby authorize Asthma, Immunology & Allergy Associates, P.C., to provide medical treatment to my child and 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 Parent/Legal Guardian ____

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 that should the account be referred to a collection agency, I agree to pay reasonable attorney fees and collection expenses.

   Date: ____________________________ Signature of Parent/Legal Guardian ____

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