Patient's Name: _____ Sex F M Age_____ Birth Date: _____ SS#:_____-____-_____

Physical Address: _____ _____
(Not a P.O. Box) City State Zip

Mailing Address: _____
City State Zip

E-Mail Address: _____ Marital Status _____ Drivers License: _____

Race: ☐ American Indian, Eskimo, Aleutian ☐ Asian, Hawaiian or Pacific Islander
Black or African American White Hispanic Other Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐Unknown **Primary Language:** _____

Employer_____ Work #: _____Address:_____
City State Zip

Spouse's Name: _____Employer:_____ Work _____ Address: _____
(Phone) City State Zip

Name of friend or relative at a different address: _____ Home Phone #: _____

Address_____ Work Phone #: _____
City State Zip

IF CHILD

Mothers Name: _____ Work # _____ Employer: _____

Driver's License #: _____ Address: _____
City State Zip

Fathers Name: _____ Work # _____ Employer: _____

Driver's License #: _____ Address: _____
City State Zip

INSURANCE INFORMATION

Responsible party: _____ Relationship: _____ Home Phone: _____

Address: _____ Work Phone: _____
City State Zip

Health Insurance through ☐Mother ☐Father Birth Date: _____ Medicare: _____

Health Insurance Company Name:_____

Address: _____
City State Zip

ID# or Cert#: _____ Group#: _____Policy #:_____

Is insurance through employment ☐YES ☐ No

Insured's Name: _____ Birth Date: _____

Other Health Insurance: _____

Insured's Name: _____ Birth Date: _____

Present Doctor: _____Address: _____ Phone:_____

Referred by: ☐ Physician ☐Friend ☐Google ☐Yellow Pages Other:_____

Referring person's name _____ Address: _____

List family members we have previously seen: _____

Please fill out HIPPA information on back

11/21/24

In general, the HIPPA privacy act gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provide the right to request confidential communications or that a communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home. I wish to be contacted in the following manner,

Check all that apply:

Telephone

Leave Detailed Message at home □Y □N
Leave call back Number at home □Y □N
Leave Detailed Message at work □Y □N
Leave Detailed Message on cell □Y □N

Choose one of the following:

Written Communication

Ok to mail to my home □Y □N
Ok to mail to mu work/office □Y □N
Ok to fax to this Child number □Y □N
(___) _____

Check all that apply:

Authorized PHI Recipients

Spouse □Y □N
Parent □Y □N
Child □Y □N
Other (Relationship) □Y □N
_____

□ **No Restriction Requested**

I understand that if my insurance requires referrals, it is my responsibility to make sure a current one is on file. I also understand that I have a right to my medical records; and because of privacy regulations, my permission is needed to release them. Therefore, if insurance is filed through Central Texas Allergy Asthma, I authorize payment directly to Central Texas Allergy Asthma and release of any medical records necessary to process insurance claim that is filed.

_____ _____

Signature or Parent or Legal guardian Signature *Date*

Signature **Date**