

Please Print When Filling Out This Form

For Office Use Only

Patient #: _____ Location: _____
 Date of First Appointment: _____

Patient Information

Patient's Name: _____
 Address: _____ Phone: () _____
Street City State Zip
 E-Mail Address: _____ Cell Phone: () _____
Your E-mail address is protected by and only used by Colorado Allergy and Asthma Centers, PC operations.
 Date of Birth: _____ Sex: Male Female Relationship Status: _____ Social Security #: _____
 Have you or any other family members received medical care by our practice? Who: _____ When: _____

Physician Information

Primary Care Physician (PCP): _____ Phone: () _____
 Address: _____ Name of Group Practice: _____
Street City State Zip
 Specialist: _____ Phone: () _____
 Address: _____ Name of Group Practice: _____
Street City State Zip
 I give permission to send a written report(s) to above Doctors: Yes No

How did you first hear about Colorado Allergy and Asthma Centers? (Check One)

Referral Source

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Primary Care Office | <input type="checkbox"/> Specialist | <input type="checkbox"/> CAAC Patient _____ | <input type="checkbox"/> Family Member _____ |
| <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> CAAC Employee _____ | <input type="checkbox"/> Advertisement _____ |
| <input type="checkbox"/> Friend _____ | <input type="checkbox"/> Community Event _____ | <input type="checkbox"/> School Screening | <input type="checkbox"/> Health Fair |
| <input type="checkbox"/> CAAC Website | <input type="checkbox"/> CAAC Newsletter | <input type="checkbox"/> A&E Clinic | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> National Public Radio (NPR) | <input type="checkbox"/> Study/Research Patient | <input type="checkbox"/> Breathe Better Bus/Foundation | <input type="checkbox"/> Other _____ |

Employment Information

Complete this area for the patient OR parent/guardian of a minor

Name: _____ Relationship: _____
 Date of Birth: _____ SSN #: _____
 Employer: _____ Phone #: _____
 Employer Address: _____
 City: _____ State: _____ Zip: _____
 E-Mail Address: _____

Complete this area for the spouse OR the 2nd parent/guardian of a minor

Name: _____ Relationship: _____
 Date of Birth: _____ SSN #: _____
 Employer: _____ Phone #: _____
 Employer Address: _____
 City: _____ State: _____ Zip: _____
 E-Mail Address: _____

Insurance

Ins. Company: _____ Phone #: _____
 Policy Holder: _____ Effective Date: _____
 Ins. Address: _____
Street City State Zip
 Member #: _____ Group #: _____

Contacts

Emergency Contact: _____
 Phone #: _____
 2nd Phone #: _____

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Billing Procedure

I authorize the release of any information necessary to process claims. I request payment of benefits to Colorado Allergy and Asthma Centers. I understand I am financially responsible for charges not covered by this authorization.

I understand and agree if care at Colorado Allergy and Asthma Centers requires Primary Care Physician referral, it is my responsibility to see that the referral is current prior to receiving care at Colorado Allergy and Asthma Centers. If no referral is present in advance, I agree to pay for charges at the time of service.

Signature _____ Relationship to Patient _____
 Witness _____ Date _____

Consent for care of minors

Because my son/daughter is a minor (less than eighteen (18) years of age) and primarily supported by parent or guardian, I understand and agree that he/she may be evaluated and/or treated by Colorado Allergy and Asthma Centers' staff if I am not present to give consent. This may include, but not necessarily be limited to, physical exams, skin tests, laboratory tests, allergy injections and the prescription of medications in my absence. This agreement will be in effect until revoked by me in writing.

Signature _____ Relationship to Patient _____
 Witness _____ Date _____