PATIENT DEMOGRAPHIC SHEET
Allergy Asthma & Pulm Clinic

LAST NAME_____**FIRST NAME**_____**MI**_____
SEX_____DOB_____AGE_____MARITAL STATUS S M D SEP W
ADDRESS_____
CITY_____STATE_____ZIP_____
HOME PHONE(____)_____WORK PHONE(_____)_____
CELL PHONE(_____)_____EMAIL_____
SS#_____DRIVERS LICENSE#_____
EMPLOYER_____OCCUPATION_____
MEDICATION ALLERGIES_____

INSURANCE INFORMATION
INSURANCE NAME_____ HMO_____ PPO_____
MAILING ADDRESS_____PHONE(___)_____
POLICY#_____GROUP#_____
COPAY_____DEDUCTIBLE_____REFERRAL REQUIRED YES__NO__
REFERRING PHYSICIAN_____
ADDRESS_____PHONE(____)_____

INSURED'S INFORMATION
INSURED'S NAME_____RELATION TO PT_____
ADDRESS_____HOME PHONE(____)_____
CITY,STATE,ZIP_____WORK PHONE(____)_____
SS#_____DOB_____EMPLOYER_____

SECONDARY INSURANCE
INSURED'S NAME_____RELATION TO PT_____
INSURANCE COMPANY_____PHONE(____)_____
POLICY#_____GROUP#_____DOB_____

I authorize Dr. Kris Bhat to release medical records to insurance for payment and for services and to the referring or primary care physician or other health care providers. I authorize and assign insurance benefits to **Kris Bhat, M.D. for** services rendered. I am responsible for all deductibles, coinsurances, co-pays and referrals when needed. Patients that schedule a sleep study and need to cancel their appointment will have to call us 24 in advance. **If you do not give a 24 hour notice, you will be charged $150.00** and insurance will not be billed for this amount. You will be held responsible for this amount.

SIGNATURE_____DATE_____

MINORS NAME_____

WITNESS_____DATE_____