MARC W. CROMIE, SR., MD
TODD A. LEVIN, MD
LEE M. PERRY, MD

PATIENT INFORMATION
(PLEASE PRINT)

HYMAN M. KAPLAN, MD
JENNIFER PATEL, MD
JESSICA VAN MASON, MD

Chart# _____

Patient's First Name: _____ Middle _____ Last _____

Address:_____City:_____State/Zip:_____

Social Security Number:_____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Date of Birth:_____ Age _____ □ Male □ Female / E-Mail:_____

Home Phone (_____)_____Work Phone (_____)_____Cell Phone (_____)_____

Nearest Relative or Friend (other than spouse): _____ Relationship: _____ Phone: (_____)_____

Employer/School: _____Employer Phone Number (_____)_____

Employer
Address:_____

Spouse's Name: _____ Employer:_____

Address: _____ Employer Phone Number (_____)_____

Relationship if a child: □ Mother □ Father □ Stepmother □ Stepfather □ Other _____

Name: _____Social Security Number _____

Birthdate:_____ Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Employer: _____ Occupation: _____

Relationship if a child: □ Mother □ Father □ Stepmother □ Stepfather □ Other _____

Name: _____Social Security Number _____

Birthdate:_____ Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Employer: _____ Occupation: _____

Name of any family member who has been a patient here:

1. Name: _____ 3. Name: _____

2. Name: _____ 4. Name: _____

Family Physician:_____ City/State: _____ Phone (_____)_____

Referring Physician:_____ City/State: _____ Phone (_____)_____

The patient (guardian) agrees to notify this office if any changes occur in the medical / health history. The patient (guardian) agrees to be fully responsible for payment of services rendered in this office, excluding any negotiated or contracted amounts from PPO/HMO insurance company that must be written off of account and are not the patient's responsibility. I am also responsible for any attorney's fees and costs of collections in the event of default. I authorize the release of any medical information necessary to process my insurance claim and request payment of benefits to the physician for the services described.

Signature: _____ **Date**:_____ _____

INSURANCE INFORMATION

Please present card to secretary when handing information sheet in

PRIMARY INSURANCE

Insured's Name:_____Relationship to Patient:_____

Insured's Social Security #:_____ Insured's Date of Birth:_____

Insured's Employer: _____

Insurance Company: _____

Mailing Address for Medical Insurance Claims: _____

_____

Identification Number:_____ Group Number:_____

Effective Dates:_____ Co-pay Amount:_____

Is referral or prior authorization required before services can be rendered?_____

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SECONDARY INSURANCE

Insured's Name:_____Relationship to Patient:_____

Insured's Social Security #:_____ Insured's Date of Birth:_____

Insured's Employer: _____

Insurance Company: _____

Mailing Address for Medical Insurance Claims: _____

_____

Identification Number:_____ Group Number:_____

Effective Dates:_____ Co-pay Amount:_____

Is referral or prior authorization required before services can be rendered?_____

PERSON RESPONSIBLE FOR THE BILL (IF OTHER THAN PATIENT)

Name: _____ Phone: (_____)_____

Address:_____

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*May we leave lab results, appointment reminders, etc. on your home answering machine? (□ Yes □ No) email? (□ Yes □ No) and/or Cell Phone? (□ Yes □ No). **Patient / Guardian Signature** _____

Notice of Privacy Practices Acknowledgement: I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). Chattanooga Allergy Clinic (CAC) may use and disclose my PHI to conduct, plan and direct my treatment and followup among multiple healthcare providers involved in my treatment, directly and indirectly, to handle billing and payment, and to conduct normal healthcare operations such as quality assessments and physician certifications. My signature below constitutes my acknowledgement that I have read, understand had have been provided with a copy of the Notice of Privacy Practices. I understand CAC has the right to change this Notice of Privacy Practices from time to time and I may contact CAC at any time to obtain a current copy.

Patient Signature: _____

*Please list below any person that you allow us to disclose medical information to; this includes, but is not limited to, appointment times, laboratory results, his/her physician's plan for health care, etc.

Name: _____ Relationship: _____

Name: _____ Relationship: _____