Austin Family Allergy & Asthma (AFAA) **Acct:** _____

Patient Demographic Sheet

Patient Last Name	Patient First Name	Marital Status	Date of Birth	Age	Sex	Social Security Number

Permanent Address	City/State/Zip	Email Address - ok to send reminders? Y ☐ N ☐

Mailing Address ☐ Same as Permanent Address	City/State/Zip	Driver's License Number (Guarantor's if Child)

Home Phone - Best number? ☐	Cell Phone - Best number? ☐ Text OK? ☐	Work Phone - Best number? ☐

Job Title	Employer	Employer's Address	City/State/Zip

Responsible Party/Guarantor if patient is under 18

Last Name of Guarantor	First Name of Guarantor	Relationship to Patient	Date of Birth	Social Security Number

Guarantor's Address ☐ Same as Patient's	City/State/Zip	Email Address - ok to send reminders? Y ☐ N ☐

Home Phone - Best number? ☐	Cell Phone - Best number? ☐ Text OK? ☐	Work Phone - Best number? ☐

Other Parent's Last Name	Other Parent's First Name	Address, if different	Apt #	City/State/Zip

Emergency Contact

Last Name	First Name	Relationship to Patient	Best Contact Number / Type (i.e. cell/work)

Address ☐ Same as Patient's	City/State/Zip	Alternate Number / Type

Insurance Information

Primary Insurance	Policy Holder	Date of Birth	Social Security Number

ID Number	Group Number	Effective Date	Phone Number

Secondary Insurance	Policy Holder	Date of Birth	Social Security Number

ID Number	Group Number	Effective Date	Phone Number

Primary Care Physician

Primary Care Last Name	Primary Care First Name	Phone Number	Address

Referral Information

Were you referred to our practice? Y ☐ N ☐

If referred by a provider:

Provider's Last name	Provider's First Name	Phone Number	Address

If referred by friend/family:			Otherwise:
Last Name	First Name	Relation	How did you hear about us?

Pharmacy Information

Pharmacy Name	Address	Phone Number	Fax Number

Consents

I give consent for AFAA to discuss patient's medical care and payment for medical care with the following people:

Name/relationship/phone#		Name/relationship/phone#		Name/relationship/phone#

I give consent for AFAA to leave a voicemail that contains PHI on the following phone number:_____

READ AND SIGN AGREEMENT WITH THE FOLLOWING STATEMENTS:

1 - I hereby give my consent for physicians of Austin Family Allergy and Asthma to evaluate and treat the above named patient.

2 - I have been provided with the Privacy Practices Notice of Austin Family Allergy and Asthma.

3 - I understand that my personal health information will be used for the purpose of treatment, payment & the coordination of health. care needs of the patient.

4 - I give permission to assign benefits for purposes of filing insurance

5 - I have also been provided and agree with the Financial Policy of Austin Family Allergy and Asthma.

Signature of Patient or Guardian: _____ **Date:** _____