



New Patient Registration Form

Please fill out this form completely – Do NOT leave blanks

Registration # _____

Canton Asthma & Allergy
P E D I A T R I C & A D U L T C A R E

Patient Name (Last) _____ First: _____ M: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Billing Address (If Different): _____

Home Phone: (____) _____ Cell: (____) _____ Birth Date: _____

SS#: _____ Gender: [] M [] F Marital Status: [] M [] S [] W [] D [] P Email: _____

Employer: _____ Work Phone: _____

Spouse/Partner Name: _____ SS# _____

Spouse/Partner Employer: _____ Work Phone: _____

Emergency Contact & Relationship: _____ Phone: _____

TREATING PHYSICIAN INFORMATION

Primary Care Physician: _____ Phone: _____

Office Address: _____ City: _____ State: _____ Zip: _____

I authorize Canton Asthma & Allergy to correspond with my Primary Care Physician(s) listed above, concerning my condition and planned treatment. [] Yes [] No

IF PATIENT IS A MINOR – PARENT/GUARDIAN MUST BE PRESENT FOR MINOR TO RECEIVE TREATMENT

Father's Name: _____ SS# _____

Father's Employer: _____ Work Phone: _____

Mother's Name: _____ SS# _____

Mother's Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____ Group #: _____

Effective Date: _____ Policyholder Name: _____ Birth date: _____

Other Insurance: _____ Policy #: _____ Group #: _____

Effective Date: _____ Policyholder Name: _____ Birth date: _____

AUTHORIZATIONS

I authorized payment directly to Canton Asthma & Allergy for services rendered. I understand I am financially responsible for any co-payments or other charges not paid by my insurance plan(s). I understand that I am responsible for services performed without a valid HMO authorization form from my primary care physician, if my insurance requires one. I understand that a referral from my primary care physician or an insurance care does not guarantee coverage and/or payment.

I give permission to the physician and/or nurse to leave lab or x-ray results on my answering service if I am unable to be contacted in person.

Signature: _____ Date: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? (Check ALL that apply)

Physician [] Insurance [] Patient [] Friend [] Family [] Yellow Pages [] Web Site [] Other: _____

It is our policy to thank those who refer patients to us. Do we have your permission to do this? [] Yes [] No

Referred by: _____ Address: _____

City: _____ State: _____ Zip Code: _____