Mainland Allergy Clinic

Susan L. Andrew MD & Ward Prentice PA-C & Kristy Cooley-O'Brien PA-C
www.allergymd.org

Main Office: 914 FM 517 W, Dickinson, TX 77539 **Phone**: 281-337-1512
Bellaire Branch: 6550 Mapleridge #217 Houston, TX 77081 **Phone:** 713-661-9003
Shared Fax: 281-534-1472

Date: ________________________ **Preferred way of contact (Check all that apply):** ☐Work ☐ Home☐ Cell ☐ Email
Name First:______________________________ **MI:**____**Last Name:**____________________________ **Suffix:**______
Address:____**City:**________________________**State:**_____**Zip:** ________
Home Phone:_______-_______-_______ **Work Phone**: _______-_______-_________ **Cell Phone**: _______-_______-_______
Email:____ **DOB:** ________________________
Sex: ☐ M☐ F **Last 4 of SS#**-__ __ __ ___ **Marital Status:** ___________ **Preferred Language:** ____________________
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed **Employer:**___________________________
Primary Insurance Company: ____☐HMO ☐PPO ☐ Self-Pay
Emergency Contact: ____**Phone #:** _____-______-______
Primary Care Provider:___________________________ **Number:** _____-_____-______**Referred By:** _____________
Pharmacy & phone number: ____
Smoking History: ☐ Current Smoker ☐ Past Smoker ☐ Never Smoked **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐Other Race ☐ Decline to Specify.
Office will use information to contact patient if necessary; if unavailable by preferred method, other avenues of communication will be used such as email or work numbers.

Party Responsible for Payment

Name: _________________________________**Relationship:** _________________ Signature: ___________________________
Address: ___________________________________**City:** _______________________ **State:** ______ **Ph #** ____-_____-______

Patients are required to pay the portion of the bill they are responsible for at the time of service.

AUTHORIZATION TO RELEASE INFORMATION & PAY BENEFITS TO THE PHYSICIAN

I authorize Mainland Allergy Clinic, its authorized agents, or any insurance company to release any medical or other information necessary to process any claim arising from treatment at this facility. I also authorize any physician or other person who has attended or examined me to disclose or testify to any knowledge or information thus acquired. I also authorize payment directly to the above named provider of the benefits otherwise payable to me for any and all services rendered at this facility. A photocopy of this authorization shall be as valid as the original.

Signature ____

Patient or Personal Representative

ACKNOWLEDGEMENT OF REVIEW OF HIPAA

I have reviewed the office's Notice of Privacy Practices Health Information Portability and Accountability Act, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature ____

Patient or personal representative

Mainland Allergy Clinic is allowed to discuss my case and release information to the following:

Name: ____ Phone #______________________________
Name: ____ Phone #______________________________
Name: ____ Phone #______________________________