Mainland Allergy Clinic

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www.allergymd.org

Date: _____ **Preferred way of contact (Please check all that apply):** ☐Work ☐ Home☐ Cell ☐ Email
First Name:_____**Middle Initial:** _____**Last Name:**_____ **Suffix:** _____
Address:_____**City:**_____**State:** _____**Zip:** _____
Home Phone: _____-_____-_____**Work**: _____-_____-_____**Cell**: _____-_____-_____
Email: _____ **DOB:** _____
Sex: ☐ M☐ F **S.S #: xxx-xx-**__ __ __ __ **Marital Status:** ☐*Single* ☐*Married* ☐*Other(eg: committed relationship)* _____
Preferred Language: _____**Primary Insurance Company:** _____☐HMO ☐PPO ☐ Self-Pay
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed **Employer:**_____
Pharmacy:_____**Pharmacy Phone:** _____
Emergency Contact: _____**Phone:** _____-_____-_____
Primary Care Provider:_____ **Number:**_____-_____-_____
Referred By: _____**Smoking History:** ☐ Current Smoker ☐ Past Smoker ☐ Never Smoked
If current smoker, *every day* or *some day smoker*? **Vaping:** ☐ Current Vaper ☐ Past Vaper ☐ Never Vaped
If current vaper, *every day* or *some day vaper*? **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.

Party Responsible for Payment

Name: _____**Relationship:** _____ Signature: _____
Address: _____**City:** _____ **State:** _____ **Phone** ____-_____-_____
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 _____

PLEASE RETURN THIS FORM TO FRONT DESK UPON COMPLETION FOR FASTER CHECK-IN