Dr. ARTHUR LUBITZ, *Allergist*
Dr. AMA ALEXIS, *Allergist*

Patient Information

Name: _____ Social Security # _____-_____-_____

Address: _____ Apt. #: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____ / _____ /_____

Home: (_____) _____-_____ Work: (_____) _____-_____ Mobile: (_____) _____-_____

Email: _____ Sex: M F (circle one) Marital Status: M S D W (circle one)

Employer Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (_____) _____-_____ x _____

Primary Care Physician or Referring Physician (to whom reports may be sent)

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (_____) _____-_____ x _____

Insurance Information

Insurance Name: _____

Policy #: _____ Date of Birth: _____ / _____ /_____

Policy Holder Name: _____

Relationship to Patient:_____ Employer: _____

Secondary Insurance? Yes or No (circle one) If Yes, please indiciate the following:

Insurance Name: _____

Policy #: _____ Date of Birth: _____ / _____ /_____

Policy Holder Name: _____

I authorize the release of medical information necessary to communicate with referring physicians and to process insurance claims. In accordance with medical treatment, there may be procedures or tests performed at additional costs. I authorize direct payment of covered benefits to the provider of services. *The patient is responsible for all fees, regardless of insurance coverage. Payment for office visits is expected at time of service. Credit cards may be used.*

_____

Signature Date