

Princeton Allergy and Asthma Assoc., P.A.

Patient Information Please use BLACK PEN ONLY & PRINT Account # _____

First Name _____ MI _____ Last Name _____
Street Address _____ Zip _____ City _____ State _____
Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____
M ___ F ___ Date of Birth _____ SS # _____ Marital Status _____
Employer _____
Contact in an emergency _____ Relationship _____ Phone _____

How did you hear about us: Physician ___ Friend ___ Name of Friend _____
Insurance ___ Newspaper ___ Internet ___ Yellow Pages ___ Family ___ Other _____
Referring Physician Name _____ Phone _____
Address _____
Primary Care Physician _____ Phone _____

Responsible Party Information (for minors under the age of 18)

First Name _____ MI _____ Last Name _____
Street Address _____ Zip _____ City _____ State _____
Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____
M ___ F ___ Date of Birth _____ SS # _____ Marital Status _____
Employer _____
Relationship: Mother ___ Father ___ Employer ___ Legal Guardian ___ Other _____

Insurance Information

Primary Insurance: _____
Policy/ID # _____ Group # _____ Effective Date _____
Subscriber First Name _____ MI _____ Last Name _____
Street Address _____ Zip _____ City _____ State _____
Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____
M ___ F ___ Date of Birth _____ SS # _____ Marital Status _____
Relation of patient to subscriber: Self ___ Spouse ___ Son ___ Daughter ___ Other _____
Employer _____

Secondary Insurance: _____
Policy/ID # _____ Group # _____ Effective Date _____
Subscriber First Name _____ MI _____ Last Name _____
Street Address _____ Zip _____ City _____ State _____
Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____
M ___ F ___ Date of Birth _____ SS # _____ Marital Status _____
Relation of patient to subscriber: Self ___ Spouse ___ Son ___ Daughter ___ Other _____

Any other insurance? _____

Authorization & Release

Please list any person(s) to whom we may release medical information _____
I authorize the release of any medical or other information necessary in the processing my claims. I also request the release of payment be made directly to Princeton Allergy & Asthma Associates, P.A.

Signature _____ **Date** _____

Would you like information on the benefits of participation in Clinical Research? Yes ___ No ___

If Yes, please read the following statement and sign below:

PAAA physicians are involved in clinical research. PAAA may provide you with information regarding clinical studies that you may want to participate in. Most of the clinical research studies are conducted by PAAA's affiliate organization, Princeton Center for Clinical Research. Any use or disclosure of your medical information for research purposes will maintain the privacy of your medical information and you will not be personally identified.

I authorize the release of my medical information to Princeton Center for Clinical Research. I understand that this authorization has no expiration and I may revoke this authorization at any time, giving written notice to the health care provider.

Signature _____ **Date** _____

5/14/2008

For office use only: Initial _____ Date _____