ALLERGY & ASTHMA
CENTER OF TEXAS

John B. Meiser, M.D., P.A.

Please complete and sign this form so we can verify that your information is correct.

Patient Last Name: _____ Patient First Name: _____

DOB: ____/____/____ SS #: _____ Driver License #: _____ State: _____

Address: _____

City: _____ State: _____ Zip Code: _____

HM #: _____ WK #: _____ Cell #: _____

Email _____

Employer: _____Occupation: _____

Mother's Name (if minor) _____Preferred phone _____

Father's Name (if minor) _____Preferred phone _____

INSURANCE INFORMATION:

Policy Holder's Name: _____ DOB: ____/____/____

Relationship to Patient: _____ Policy Holder Insurance ID #: _____

Policy Holder Address: _____

City: _____ State: _____ Zip Code: _____

Policy Holder Employer: _____

Primary Insurance Plan (Present Actual Card): _____

Secondary Insurance Plan (Present Actual Card): _____

Emergency Contact Name: _____ Relationship: _____

HM #: _____ WK #: _____ Cell #: _____

I hereby assign to Allergy & Asthma Center of Texas all of my right, title and interest of the insurance/health and welfare benefits otherwise payable to me. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assigned to release all information necessary to secure payment.

Signature: _____ Date: ____/____/____

PLEASE PRESENT INSURANCE CARD(S) AND DRIVER LICENSE TO THE RECEPTIONIST WITH YOUR COPAY.