Allergy Medical Group
of the North Area, Inc.
The experience you trust for the relief you need

Roseville • 935 Reserve Drive • Roseville, CA 95678 • Phone: 916.782.7758 • Fax: 916.782.7770
Sacramento • One Scripps Dr., Suite 105 • Sacramento, CA 95825 • Phone: 916.925.1056 • Fax: 916.925.5908
Yuba City • 887 Plumas St., Suite A • Yuba City, CA 95991 • Phone: 530.755.3352 • Fax: 530.755.3067

PATIENT INFORMATION

Patient Name _____ Birth Date _____ Sex _____
Last First Middle Initial

Address _____ City _____ State _____ Zip _____

Phone _____ Cell Phone _____ E-mail _____

Soc. Security # XXX-XX- _____ Employer _____

Employer Address _____ City _____ State _____ Zip _____

Business phone _____ Occupation _____

INSURANCE INFORMATION _____

Primary Insurance Co. _____ Policy Holder _____ Birth Date _____

Primary Holder's SS# or ID# _____ Group# _____ HMO Group Name _____

Relationship to Patient _____ (self, spouse, child, other)

Secondary Insurance Co. _____ Policy Holder _____ Birth Date _____

Policy Holder's SS# or ID# _____ Group# _____ HMO Group Name _____

Relationship to Patient _____ (self, spouse, child, other)

Medical Savings Account YES _____ **NO** _____

Medical Savings Account# _____ **Employer** _____ **Self** _____

EMERGENCY INFORMATION _____

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

REFERRAL INFORMATION _____

Name of Primary Care Physician _____ Phone _____

Name of Referring Party _____ Phone _____

FINANCIALLY RESPONSIBLE PARTY (Must be completed if patient under 18 or a student) _____

Name _____ Relationship _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Phone _____ Work Phone _____ Soc. Security# XXX-XX- _____

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AUTHORIZATION, RELEASE AND FINANCIAL RESPONSIBILITY: I hereby authorize payment directly to the doctor of any medical benefits otherwise payable to me. I understand that I am financially responsible to him for charges not covered or not paid by insurance. I authorize him to release all information requested to support my claim. I understand that I am responsible for reporting any insurance changes to the office and that if I fail to do so, I will be responsible for any payments of services rendered. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature Date

SELF-REFERRAL ACKNOWLEDGEMENT: I understand that if at any time my insurance plan may not cover my services, I agree to pay all charges.

_____ _____
Signature Date

MEDICARE AUTHORIZATION: I request that payment of Medicare benefits be made either to me or on my behalf to Allergy Medical Group of the North Area, Inc. for any services rendered by the physician. I understand that I am financially responsible for any deductible, coinsurance or non-covered services. Coinsurance and deductible amounts are based upon the charge determination of the Medicare carrier.

_____ _____
Signature Date

INTERESTED IN FDA APPROVED CLINICAL STUDIES? **YES** _____ **NO** _____