Allergy, Asthma & Sinus Center, P.A.

Gurdev S. Judge, MD **Stephen Begley, P.A.-C**

Board Certified in Allergy and Immunology - Pediatrics and Adult

Cary
401 Keisler Drive, Suite #201,
Cary, NC 27518
T: (919) 859–5966 F: (919) 859–4993

North Raleigh
10931 Raven Ridge Road, Suite #111,
Raleigh NC 27614
T: (919) 870–6440 F: (919) 859–4993

Wake Forest
1906 S. Main Street, Suite #216,
Wake Forest NC 27587
T: (919) 562–7195 F: (919) 859–4993

Personal & Family Information

Patient Last Name: _____First Name: _____ MI: _____ DOB: _____Age: _____Today's Date: _____

Sex: _____ Race: _____ Marital Status: _____ SS#: _____ Driver's License #: _____

Home Address: _____City: _____ State: _____ Zip: _____

Phone #: Home: ( ) _____ Cell: ( ) _____ Business: ( ) _____

Occupation: _____ Employer's Name & Address_____

Spouse's Name: _____ Employer: _____ Work Phone: _____

Insurance Information:

Name & address of Primary Insurance Co.: _____

Name of Insured Policy Holder: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's SS #: _____ Effective Date Of Coverage: _____ _

Employer's Name & Address: _____ _____

Insurance Company's Phone: _____ Policy (ID)#: _____ Group #:_____

Deductible: $_____ ☐ Met How much met?:_____ ☐ Not met ☐ Not sure Starts When?_____

Does your insurance cover treatment of allergies: _____ Method of payment: ☐ Cash ☐ Check ☐ Master or Visa

Is there any Pre-existing Clause in your insurance policy? ☐ No ☐ Yes

Personal Physician: _____ Location & Phone #: _____

Referring Physician: _____ Location & Phone #: _____

How did you learn about us: _____

In case of emergency whom should we notify**?**

1. _____ Relationship:_____ Phone #: Home:_____ Work: _____
2. _____ Relationship: _____ Phone #: Home: _____ Work:_____

I authorize Allergy, Asthma & Sinus Center as follows:

- To use of this form as authority to submit claims and receive payment from my health insurance company.
- Release of any medical information necessary to my insurance company to process the claims.
- To use of a copy of this authorization in place of the original.

Patient's or Guardian's **signature:** _____ **Relationship:** _____ **Date:** _____