Date____ /____ /____

ALLERGY & ASTHMA ASSOCIATES (OVER)
Andrew Hirsch, M.D.

Patient Information

Patient Name: _____
Last First M.I.

Address:_____
Street Apt #

_____
City State Zip

Date of Birth: _____/_____/_____Race_____

Ethnicity_____ Language_____

Phone (H): _____ Phone (C): _____

SS#_____ Sex: □ Male □ Female
Marital Status: □ Single □ Married □ Divorced □ Widowed

Who referred you to us? _____

Primary Care Physician: _____

Address:_____
Street City State

Pharmacy _____
Phone

E-Mail Address:_____
(Please provide if you would like electronic copies of test results/additional information)

Patient's Employment Status

□ Employed □ Unemployed □ Retired □ Student (Full Time or Part Time)

Name of Employer_____

Address: _____

Name of School:_____

Guarantor

(If other than patient, person financially responsible for payment)

Guarantor's Name: _____
Last First M.I.

Address: _____
Street Apt #

_____
City State Zip

Phone (H): _____ Phone (W) :_____

Guarantor's SS# _____ Date of Birth ____/____/_____

Employer Name:_____

Address: _____
Street Apt #

_____
City State Zip

Insurance Information

Policy #1 (Primary)

Insurance Co. Name: _____

Address:_____
Street

_____
City State Zip

Phone: _____

Policyholder's Name: _____
Last First M.I

Policyholder's Social Security # _____

Policyholder's Birth Date: _____/_____/_____

Relationship to Patient: □ self □ spouse □ parent □ guardian

Policyholder's Employer: _____

Policyholder's ID#:_____

Group#:_____ Referrals Needed: □ Yes □ No

Policy #2 (Secondary, if Applicable)

Insurance Co. Name: _____

Address:_____
Street

_____
City State Zip

Phone: _____

Policyholder's Name: _____
Last First M.I

Policyholder's Social Security # _____

Policyholder's Birth Date: _____/_____/_____

Relationship to Patient: □ self □ spouse □ parent □ guardian

Policyholder's Employer: _____

Policyholder's ID#:_____

Group#:_____ Referrals Needed: □ Yes □ No

Emergency Contact Information

Name: _____
Last First M.I.

Relationship:_____ Phone: _____

Assignment and Release

ALL PATIENTS

I hereby assign, transfer and set over to **Allergy and Asthma Associates**, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I may be financially responsible for all charges whether or not they are covered by my insurance.

Patient's Signature: _____

Date:_____

ALL PATIENTS

I acknowledge that I have received a copy of **Allergy and Asthma Associates** notice regarding Privacy of Personal Health Information.

Patient's Signature: _____

Date:_____

ALL PATIENTS

I agree to provide accurate and current insurance information for myself or my dependent. I assume full financial responsibility for balances resulting from inaccurate and/or outdated insurance information.

Patient's Signature: _____

Date:_____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to **Allergy and Asthma Associates** for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____

Date:_____

MEDIGAP PATIENTS ONLY

I request that payment of authorized Medigap benefits be made on my behalf to **Allergy and Asthma Associates** for any services. I authorize any holder of Medicare information about me to release to Allergy and Asthma Associates any information needed to determine these benefits payable for related services.

Patient's Signature: _____

Date:_____

Allergy & Asthma Associates, Inc.
Andrew Hirsch, M.D.

258 Broad Street
Red Bank, NJ 07701

219 Taylors Mills Road
Manalapan, NJ 07726