WELCOME

ALLERGY & ASTHMA CLINIC OF KENOSHA, SC ALLERGY & ASTHMA CLINIC OF RACINE

PLEASE FILL THIS REGISTRATION INFORMATION

Patient Name:_____ DOB: / / Sex: M F Marital Status: S M D W SEP
Address _____ City/St./Zip_____ Soc. Sec# / /
Tel. Home: ( ) / Cell: ( ) / Email:_____
Race: White / Black or African American / American Indian or Alaska Native /Asian / Hispanic /Latino/ Other
Person to contact in case of emergency: Name:_____ Tel: ( ) /
To protect the privacy of your medical information please give us the phone number/s we can use to contact you.
Tel# _____ Can we leave information on answering machine? Yes No
Can we leave information with a family member? N Y If yes with whom?_____

Employed: N Y Occupation_____
Employer Name & Address _____ Tel # _____
Spouse Name_____ Address _____ Tel # _____
Spouse Employer _____ Address _____ Tel # _____
Insured Name _____ Address _____ Tel # _____
Preferred Language _____ Preferred Pharmacy _____

IF PATIENT IS A MINOR PLEASE GIVE THE FOLLOWING INFORMATION:
Parents Name _____ Address & Tel # (if Different) _____
Parents Employer Address & Tel # _____
Person to Contact in Case of Emergency _____ Tel # _____

Family Physician _____ Address _____ Tel# _____
How did you find us? Referred by Physician/ Name_____ Y. Pages / One Book/ New Paper Ad
Office Sign/ Relative/ Friend / Heard on Radio Other Please give Name of Source_____

Name of Person Responsible for Payment:_____
Primary Ins. Co.: _____ ID# _____ Group # _____
Effective Date:_____ Employer _____ Insured Name _____
Relationship to Patient: _____ DOB: / / Soc. Sec. / / Insured Tel ( ) /

ANY OTHER INSURANCE? NO YES. If yes, please fill the secondary insurance information
Name of Person Responsible for second insurance _____
Secondary Ins. Co.: _____ ID# _____ Group # _____
Effective Date:_____ Employer _____ Insured Name _____
Relationship to Patient: _____ DOB:_____ Insured Tel# _____

I give consent for examination, testing and treatment by Kulwant S. Dhaliwal, MD and/or Amrit K. Dhaliwal, MD for myself / spouse or child.
I authorize the doctors or the clinic, to apply for insurance benefits for services provided and release any information to process the insurance claim. I also authorize my insurance company to make payment of benefits directly to the clinics or doctors. I permit a copy of this authorization to be used in place of the signature requested on claim form. This authorization may be revoked, in writing, by me at any time. I will be responsible for the co-pays each visit, insurance deductibles, or any percentage not covered by my insurance.
I have read and understood the above statement.
Signature _____ Date_____ Relationship to Patient_____