

WELCOME

ALLERGY & ASTHMA CLINIC OF KENOSHA, SC

ALLERGY & ASTHMA CLINIC OF RACINE

PLEASE FILL THIS REGISTRATION INFORMATION

Patient Name _____ DOB _____ Sex: M F Soc. Sec # _____
Address _____ City/State/Zip _____
Tel # _____ Marital Status: S M D W SEP E-mail @ _____

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? Yes No. If yes with whom? _____

Employed: Y N Occupation _____
Employer Name & Address _____ Tel # _____
Spouse Name _____ Address _____ Tel # _____
Spouse Employer _____ Address _____ Tel # _____
Insured Name _____ Address _____ Tel # _____

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 Heard on Radio Relative Friend Other Please give Name of Source _____

Person Responsible for Payment: _____
Primary Ins. Co.: _____ ID# _____ Group # _____
Effective Date: _____ Employer _____ Insured Name _____
Relationship to Patient: _____ DOB: _____ Insured Tel _____

ANY OTHER INSURANCE? NO YES. If yes, please fill the secondary insurance information

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 _____