UNITED MEDICAL ASSOCIATES
ADULT & PEDIATRIC ALLERGY / IMMUNOLOGY/ ASTHMA

PATIENT INFORMATION

Name	Social Security Number (SSN)	Date of Birth	
Home Address	City	State	Zip
Mailing Address (if different from above)	City	State	Zip
Daytime Phone	Evening Phone		
Sex ❑ Male ❑ Female / Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated	Spouse's name	Healthcare Proxy ❑ Yes ❑ No	
E-mail address (optional)			
Referring Physician's Name & Address			

EMPLOYMENT INFORMATION

Employed ❑ Yes ❑ No	Employer (Parent's employer if minor)	Occupation
Employer's Address	City, State, Zip	Phone
Spouse's Employer		Spouse's SSN
Spouse's Employer Address	City, State, Zip	Phone

RESPONSIBLE PARTY INFORMATION

Person Responsible for Medical Expenses	Relationship to patient		Phone
Address	City	State	Zip

PRIMARY INSURANCE INFORMATION

Insurance Company	Policy Number	Medicare Number	Medicaid Number
Subscriber's name	Subscriber's Relationship to patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other:		
Address of Insurance Company			

SECONDARY INSURANCE INFORMATION

Insurance Company	Policy Number	Medicare Number	Medicaid Number
Subscriber's name	Subscriber's Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other:		
Address of Insurance Company			

EMERGENCY INFORMATION

Person to Contact in Case of Emergency, Other than Spouse				Relationship to Patient
Address	City	State	Zip	Phone

AUTHORIZATION

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance. I certify that the information I have reported with regard to my insurance coverage is correct.

Patient's Signature	Date	Spouse's Signature	Date