nyasc
Allergy & Sinus Centers

PATIENT INFORMATION

FIRST NAME:	MIDDLE NAME:	LAST NAME:	DOB:

SEX: ☐ FEMALE ☐ MALE | GENDER IDENTIFICATION _____ | MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED | PATIENT IS: ☐ STUDENT ☐ CHILD

ETHNICITY:
DO YOU CONSIDER YOURSELF HISPANIC/LATINO? ☐ YES ☐ NO

RACE:
☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN
☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ WHITE ☐ OTHER RACE
_____

ADDRESS:	APT#

CITY/STATE/ZIP:	EMAIL:

HOME PHONE:	CELL PHONE:	WORK PHONE:

PREFERRED METHOD OF CONTACT:
☐ HOME PHONE ☐ CELL PHONE ☐ EMAIL ☐ PATIENT PORTAL ☐ OTHER _____

PREFERRED LANGUAGE:
☐ ENGLISH ☐ SPANISH ☐ OTHER _____

EMERGENCY CONTACT

EMERGENCY CONTACT NAME:	EMERGENCY CONTACT PHONE #:	RELATIONSHIP TO PATIENT:

INSURANCE SUBSCRIBER

PATIENT'S RELATIONSHIP TO SUBSCRIBER:
☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER _____

NAME:	DOB:

ADDRESS:	APT#

CITY/STATE/ZIP:	PHONE:	EMAIL:

GUARANTOR (TO WHOM PRACTICE COMMUNICATIONS ARE SENT)

PATIENT'S RELATIONSHIP TO GUARANTOR:
☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER _____

NAME:	DOB:

ADDRESS:	APT#

CITY/STATE/ZIP:	PHONE:	EMAIL:

HOW DID YOU HEAR ABOUT NYASC

☐ ZOCDOC (LINK FROM OUR WEBSITE) ☐ ZOCDOC (DIRECTLY) ☐ NYALLERGY.COM ☐ ADVANCEDALLERGYNY.COM ☐ FAMILY/FRIEND ☐ DOCTOR ☐ HEALTH CENTER ☐ YAHOO
☐ GOOGLE ☐ YELP ☐ WORK ☐ RADIO ☐ TV ☐ METRO NY ☐ NY POST ☐ OTHER _____

YOUR OTHER DOCTORS

PRIMARY CARE PHYSICIAN:	PHONE:

RFERRING DOCTOR:	PHONE:

ENT:	PHONE:

YOUR PHARMACY INFORMATION

☐ **I Authorize NYASC to obtain/have access to my medication history.**

PREFERRED PHARMACY NAME:	

PREFERRED PHARMACY ADDRESS:	PREFERRED PHARMACY PHONE:

I certify that I have read and agree to New York Allergy & Sinus Group, PLLC. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to NYASC all money to which I am entitled for medical expenses related to the services performed from time to time by NYASC, but not to exceed my indebtedness to NYASC. I authorize NYASC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $25.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from NYASC by voice, text or email at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to New York Allergy & Sinus Group, PLLC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of New York Allergy & Sinus Group's Privacy Notice. _____ *(Initials)*

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY | NAME OF PATIENT OR RESPONSIBLE PARTY *(PLEASE PRINT)* | DATE