ALLERGY & ASTHMA ASSOCIATES OF MURRAY HILL

35 East 35 Street
New York, NY 10016

(212) 685-4225
(212) 696-5682

Dr. Rubin   Dr. Ehrlich   Dr. Teitel

PATIENT REGISTRATION
(Please Print)

Patient Name:	Date of Birth:	Age:	Sex: M F	SS#:
Street Address:	Apt #:		Marital Status: S M W D Sep	
City:	State:		Zip:	
Home Phone #:	Secondary #/ Cell #:			
Email Address:	Emergency Contact:		Phone # and Relationship:	
Spouse Name:	Phone#:			
Mother / Guardian Name: Phone #:	Father / Guardian Name: Phone #			
Primary Care Physician / Pediatrician:			Referred By:	
Physician Address:			Phone #	

PATIENT EMPLOYER INFORMATION

Employer Name:	Phone#:	Occupation:
Address:	City/State:	Zip:

INSURED PERSON (IF NOT PATIENT)

Name:	DOB:	SS#:
Street Address:	City/State:	Zip:
Phone #:	Relationship to Patient:	
Employer Name:		Phone #:

INSURANCE

Primary:		
ID#:	Group #:	Phone #:
Secondary:		
ID#:	Group #:	Phone #:

Please Send All Balance Statements / Bills To:

Name:	Phone#:
Address:	Relationship:

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: Signature:
Patient, Parent or Guardian

I hereby authorize Dr. _____________________ to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request payment from my insurance company be made directly to the Doctor (or to the party who accepts assignment). I certify that this information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date: Signature:
Patient, Parent or Guardian