

Frisco Allergy & Asthma Center (FAAC)
Eric J. Schmitt, MD

New Patient Registration

Patient Name: _____ M F DOB: ____ / ____ / ____ SS#: _____
(print)

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

E-mail: _____ Married Single Divorced

Name of Emergency Contact: _____ Relation: _____

Contact #: _____

Relation to Insured: Self Spouse Parent Other: _____

Primary Insurance Information

Name of Primary Policy Holder: _____ DOB: ____ / ____ / ____ SS#: _____

Employer: _____ Address: _____

Phone (H): _____ Wk: _____ Cell: _____

Insurance Co.: _____ Group #: _____

Policy ID #: _____ Benefit Verification Phone #: _____

Secondary Insurance Information

Name of Primary Policy Holder: _____ DOB: ____ / ____ / ____ SS#: _____

Employer: _____ Address: _____

Phone (H): _____ Wk: _____ Cell: _____

Insurance Co.: _____ Group #: _____

Policy ID #: _____ Benefit Verification Phone #: _____

Financial Responsibility

FAAC will process insurance claims for my convenience. I understand that co-pays, deductibles and procedures not covered by my insurance are my responsibility. I understand that FAAC will attempt to verify my coverage, but if my insurance fails to reimburse despite these efforts, I am responsible for paying the bills in full. I understand that I am responsible for knowing what my insurance benefits are and obtaining referrals when required. I will inform any changes in my insurance plan immediately. Any charges that result from failure to do so will be solely my responsibility. Payments authorized for services performed are property of Eric Schmitt, MD PLLC. ____ initial

Patient/Parent Signature: _____ **Date:** _____