

Frisco Allergy & Asthma Center (FAAC) REGISTRATION FORM

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PATIENT INFORMATION

Patient's Last Name:		First:	Middle:	Sex:	Marital status (circle one)
				<input type="checkbox"/> Male <input type="checkbox"/> Female	Single / Mar / Div / Sep / Wid
Is this your legal name?	If not, what is your legal name?	Date of Birth:	Age:	Social Security #	
<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /			
Street address:		City:	State:	Zip Code:	

Please check best contact phone number below:

Home Phone: () Work Phone: () Cell Phone: ()

Email Address

Patients employment status: **Employer:** **Employer Phone:**
Active \ Retired \ Student

Pharmacy Name: **Pharmacy location \ Phone:**

Chose clinic because/Referred to clinic by (please check one box): Family/Friend Internet Ad Physician Insurance Plan
 Other

Referral Name: (If physician, please provide phone number) **Referring Physician's Number:**
()

Primary Care Physician: **Primary Care Physician's Number:**
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Responsible Party/Policy holder's name: **Date of Birth:** **Social Security #:**
/ /

Insurance name: Check if address of policy holder is the same as above. If not, please provide the complete address below:

Patient's relationship to policy holder: Self Spouse Child Other

Policy holder's employment status: **Employer:** **Employer Phone:**
Active \ Retired \ Student ()

Secondary Policy/Policy holder's name: **Date of Birth:** **Social Security #:**
/ /

Insurance name: Check if address of policy holder is the same as above. If not, please provide the complete address below:

Patient's relationship to policy holder: Self Spouse Child Other

Policy holder's employment status: **Employer:** **Employer Phone:**
Active \ Retired \ Student ()

IN CASE OF AN EMERGENCY

Name of local friend or relative (not living at same address): **Relationship:** **Home or Cell Phone:** **Work Phone:**
() ()

FAAC will process insurance claim for my convenience. I understand that co-pays, deductibles and procedures not covered by my insurance are my responsibility. I understand that I am responsible for knowing my insurance benefits; however FAAC will attempt to verify my coverage for charges on date of services. If insurance fails to reimburse for services recommended or provided despite these efforts, I am responsible for total bill whether the services are performed at our facility or an outside location. I will inform any changes regarding my insurance immediately. Any charges that result from failure to do so will be solely my responsibility.

Patient/Guardian Signature: _____ **Date:** _____