



INTERNAL USE ONLY

Patient Name _____
Chart/Account # _____ DOB _____
Doctor _____
Date _____

NEW PATIENT INFORMATION

Patient _____ Social Security No. _____
(Last) (First) (M)

Address _____
(Street or Route) (City) (State) (Zip) (County)

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Home Phone _____ Cell Phone _____ Business Phone _____

Yes [] No [] Leave Medical Message On Answering Machine

Occupation _____ Employer _____

Employer's Address _____ Personal Email _____
(Street or Route) (City) (State) (Zip)

Referring Doctor _____ Primary Doctor _____

Address _____ Address _____

How did you learn about us? Doctor Referral [] Friend [] Yellow Pages [] Advertisement [] Other _____

Responsible Party (If other than Patient) _____

Address _____
(Street or Route) (City) (State) (Zip)

DOB _____ SS# _____

Emergency Contact _____ Phone _____

Address _____
(Street or Route) (City) (State) (Zip)

Is This A Work Related Visit? Yes [] No []

INSURANCE INFORMATION

Primary Insurance _____

Secondary Insurance _____

Address _____

Address _____

City & State _____

City & State _____

Name of Policyholder _____

Name of Policyholder _____

Policy ID Number _____

Policy ID Number _____

Group ID Number _____

Group ID Number _____

Primary Cardholder SS# _____

Primary Cardholder DOB _____

Does Your Insurance Company Require Prior Authorization for Hospitalization Yes [] No []

Medication Prescription Preference? [] One Month [] 3 Months

No Show Charge of \$50.00 For All Missed Appointments.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Dakota Allergy & Asthma to furnish information to my insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself and my dependents. I understand that it is my responsibility to pay for all charges for the services incurred. It is my responsibility to inform you if my insurance company requires prior authorization for hospitalization.

Signature _____ Date _____

MEDICARE AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature _____ Date _____

605-336-6385 Fax 605-336-6513

2200 West 49th Street, Suite 104, Sioux Falls, SD 57105 dakotaallergy.com

Mark E. Bubak, MD | Brian A. Brennan, MD | Lindsey R. Peterson, CNP