Dakota Allergy & Asthma

INTERNAL USE ONLY
Patient Name _____
Chart/Account #_____ DOB _____
Date _____
Doctor _____

NEW PATIENT INTAKE FORM

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 _____ Email _____

Yes ☐ No ☐ Leave Medical Message On Voice Mail Preferred Contact Method: Phone ☐ Cell ☐ Email ☐ Business Phone ☐

Occupation _____ Employer_____ _____

Employer's Address _____ Business Phone _____
(Street or Route) (City) (State) (Zip)

Referring Doctor_____ Primary Doctor _____

Address _____ Address _____

How did you learn about us? Doctor Referral ☐ Friend ☐ Google ☐ Advertisement ☐ Other_____

Responsible Party (If other than Patient) _____Parent Name (if Minor Patient):_____

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

DOB _____SS#

Emergency Contact _____Phone _____

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

Custodian(s) of minor patient (if applicable):_____ Is This A Work Related Visit? Yes ☐ No ☐

Preferred Pharmacy:_____ Pharmacy Address: _____

INSURANCE INFORMATION

Primary Insurance _____
Address _____
City & State _____
Name of Policyholder _____
Policy ID Number _____
Group ID Number _____
Primary Cardholder SS# _____
Primary Cardholder DOB _____

Secondary Insurance _____
Address _____
City & State _____
Name of Policyholder _____
Policy ID Number _____
Group ID Number _____

Note: Patients are responsible for checking if Dakota Allergy & Asthma is in-network with their insurance.

Medication Prescription Preference? ☐ One Month ☐ 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.

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_____

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