Camille A. Graham, M.D. Neil M. Vora, M.D. Wha-Joon Lee, M.D. Michael J. Wiebel, M.D.

Patient Information

Name (Last)________________________(First)_______________________DOB____/____/____(Age)______
Social Security #__________________________________ TDL# ___________________________________
Marital Status: S M D W Sex: M F Race: _____________________ Ethnicity: __________________
Primary Language: ____________________________ Preferred Communication: Voice Call Text Email
Address (Street)________________________________ (City)_______________(St)_____(Zip)__________
Phone (Home)____________________________________ (Cell)_____________________________________
Employer: _________________________ Wk Phone: ____________________ Email: ___________________

Parent/Guardian Information (if patient is under 18)

Name (Last)_____________________________(First)__________________________DOB_____/_____/_____
Relationship to Patient: ______________________________________ Email: __________________________
Social Security #________________________________ TDL# ___________________________________
Marital Status: S M D W Sex: M F
Address (Street)_________________________________ (City)______________(St)______(Zip)________
Phone (Home)____________________________________ (Cell)____________________________________
Employer: ______________________________________ Wk Phone: ______________________________

Spouse Information

Name (Last)______________________________(First)_________________________DOB_____/_____/_____
Social Security #_______________________________ TDL# ___________________________________
Marital Status: S M D W Sex: M F
Address (Street)_________________________________ (City)______________(St)______(Zip)________
Phone (Home)____________________________________ (Cell)____________________________________
Employer: ______________________________________ Wk Phone: _____________________________

Insurance Information

Primary Insurance: __________________________Insurance Phone#_________________________________
Insured Name: _____________________________DOB: _____________ Relationship to Patient____________
Insured ID#____________________________Group#_________________Employer______________________

Secondary Insurance: ________________________ Insurance Phone#________________________________
Insured Name: _____________________________DOB: ___________Relationship to Patient_____________
Insured ID#____________________________Group#_________________Employer______________________

Emergency Contact (NOT LIVING WITH YOU)

Name (Last)___________________(First)_________________ Relation to Patient _____________DOB ______
Phone (Home)____________________(Work)_____________________(Cell)____________________________
Were you referred to us by another physician? _______ **If yes Dr. (name)** ______________________________
Name of your Primary Care Doctor: ____
Preferred Pharmacy Name & Number: ____
What number can we contact you at? _____________________________Can we leave a message? _________
Family Member(s) we can release information to (name & relationship): _________________________________

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Authorization to Treat, Authorization to Release Information & Assignment of Benefits, No Show & Results

I authorize the physician(s) of Allergy ENT to treat me. I authorize any physician/agent of Allergy ENT to release my medical records or medical information to any physician, hospital or other medical provider or supplier who may participate in my medical care. I authorize any physician, hospital, or other supplier to release my medical records and information to the physician(s) of Allergy ENT. I authorize any physician/agent of Allergy ENT to release my medical records and/or information to my insurance carrier to determine my benefits. I authorize my insurance carrier(s) to pay my medical benefits directly to the physician(s) of Allergy ENT. I understand that I am financially responsible for all charges not paid by the insurance carrier(s). I understand that if I fail to give correct insurance information and the office miss filing deadlines, I am responsible for the charges in full. I understand if I have an HMO POLICY, I am responsible for obtaining the referral and make sure I have a current referral for each visit. There will be a $35.00 no show fee if I no show my regular appointment & a $50.00 no show fee for a scheduled VNG or allergy screen appointments.

**********PLEASE NOTE RESULTS WILL NOT BE GIVEN OVER THE PHONE, FOLLOW UP APPOINTMENT WILL BE REQUIRED**********

____ Date: ______________________
Patient Signature (Parent or Guardian, if patient is a minor)