NEW PATIENT INFORMATION

Patient Information

Last Name	First Name	MI
Street Address	email address:	
Zip City	State Phone: Is this a Cell phone? Y/N ( )_____--_____ Carrier_____	
Maiden Name	DOB Sex: M / F	SSN#
Marital Status ☐ Single ☐ Married ☐ Other	Student (YES / NO) ☐ Full time ☐ Part time	
Employer		
Employer Address		
Driver's License Number	Referring Physician	Referring Physician Phone # ( )
Emergency Contact	Emergency Phone ( )	Relationship:

Insurance Information

Primary Insurance Co.	Insurance#	Group#	
Insured Name:	Insured Address		
Insured Date of Birth:	Home Phone: ( )	Wk Phone: ( )	Sex: M / F
Insured Employer	Relationship of Patient to insured		
Secondary Insurance Co.	Insurance#	Group#	
Insured	Insured Address		
Insured DOB:	Home Phone: ( )	Wk Phone: ( )	Sex: M / F
Insured Employer	Relationship of Patient to insured		

Responsible Party (fill out only if other than the patient)

Last Name:	First Name:		MI
Street Address	City	State	Zip
Relationship to patient:	DOB: SS#		Sex: M / F
Employer:	Work Phone: ( )	Home Phone: ( )	

Other Family Members that are Patients of Dr. Dilley / Christopher Calabria, M.D. / Phillip McAllister, P-AC

Name	Relationship
Name	Relationship

Signing This Form Indicates That All Charges Have Been Explained

Payment Policy:
All Professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. Full payment is expected at time of each office visit unless arrangements have been made in advance. Billing information will be provided to expedite patient reimbursement form private insurance carriers.

Authorization of Payment:
I the undersigned certify that I (or my dependent) have insurance coverage as indicated above and assign directly to Dilley Allergy & Asthma Specialists, LLP all Insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the provider of services to release medical information concerning my examination and/or treatment for insurance purposes and to receive direct payment for medical benefits payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient or Responsible Party Signature: _____Date: _____