

Date: _____

Robert E. Younger III, M.D.
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The Allergy and Asthma Group
CHILD PATIENT INFORMATION

REFERRED BY _____ PRIMARY CARE PHYSICIAN _____ Phone _____

PATIENT _____
First Middle Last Preferred Name

Age _____ Birthdate _____ Male Female S. S. # _____ Phone (_____) _____
Area Code

Address _____
Street Name or PO Box

City State Zip Code

FATHER'S NAME _____
First Middle Last SS# Birthdate

Address _____
Street Name or PO Box City State Zip Code Phone (_____) _____
Area Code

Employer _____ Business Phone (_____) _____
Address Area Code

MOTHER'S NAME _____
First Middle Last SS# Birthdate

Address _____
Street Name or PO Box City State Zip Code Phone (_____) _____
Area Code

Employer _____ Business Phone (_____) _____
Address Area Code

EMERGENCY INFORMATION: Friend or relative at different address: _____

Name
Address Phone (_____) _____
Area Code

INSURANCE INFORMATION

1. _____
Name of Insurance Insured's Name

Policy or I.D. Group #

2. _____
Name of Insurance Insured's Name

Policy or I.D. Group #

Medicare # _____ GA/TN Medicaid # _____

YELLOW/GREEN CARD

Payment is due when services are rendered!

Our office policy states that the parent/legal guardian requesting treatment for the child is responsible for all fees of services rendered.

1. AUTHORIZATION TO TREAT AND RELEASE OF INFORMATION: I hereby authorize Asthma, Immunology & Allergy Associates, P.C., to provide medical treatment to my child and release any social and medical information acquired in the course of my examination or treatment for the purpose of filing for insurance benefits and other financial coverage.

Date _____ Signature of Parent/Legal Guardian _____

2. AUTHORIZATION TO PAY: I hereby authorize payment of medical benefits directly to Asthma, Immunology & Allergy Associates, P.C. I understand that I am financially responsible for the charges not covered by this assignment and that should the account be referred to a collection agency, I agree to pay reasonable attorney fees and collection expenses.

Date: _____ Signature of Parent/Legal Guardian _____

IN ORDER FOR ALLERGY TESTING TO BE MOST ACCURATE, PLEASE DO NOT TAKE ANY ANTIHISTAMINES FOR AT LEAST 5 DAYS BEFORE YOUR APPOINTMENT.