Allergy & Asthma Specialists, Ltd.

PATIENT INFORMATION

Name:	**Preferred language: ___English Other ______________**
Address:	**Date of Birth:**
City:	**Social Security #**
State: Zip:	**Sex: Male____ Female____**
Home Phone#:	**Referring Physician:**
Work Phone#:	**Family Dr:**
Cell Phone#:	**Emergency Contact:**
Email address:	**Emergency Phone#:**
Marital Status: Single Married Widowed Divorced	**Emergency Relationship:**
Possibility of Pregnancy: Yes No	**Employer:**
Race: ___Black/ African American ___White ____Asian	**Employer address:**
___Pacific Islander ___Native American ___Other	**Spouse's Name:**
Ethnicity: ___ Hispanic/Latino ____ Non-Hispanic/Latino	**Spouse's Employer:**

RESPONSIBLE PARTY INFORMATION

Name:	**Date of Birth:**
Address:	**Social Security#:**
City:	**Employer:**
State: Zip:	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State: Zip:**
Cell Phone#:	**Relationship to Patient**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Member#:	**Member#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Effective Date:	**Effective Date:**
Subscriber Name:	**Subscriber Name:**
Subscriber Date of Birth:	**Subscriber Date of Birth:**

Treatment and Financial Responsibility Statement

A. I hereby apply for treatment by the above physicians and/or their assistants. Such treatment is to include X-Rays, injections, preparation of allergy serum, skin testing and such other office procedures as they deem necessary.

B. I, (patient,guarantor) accept responsibility to pay for all services rendered on my behalf.

In the event of default on any payments due ALLERY & ASTHMA SPECIALISTS, LTD, I agree to pay all costs of collection, including 33% of attorney fees.

C. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to ALLERGY & ASTHMA SPECIALISTS, LTD.

Signature of Patient/Guarantor: ____ Date: _______________ Witness: _________________________

Notice of Deemed Consent HIV Blood Testing

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of the patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of exposure, you will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies pursuant to this provision. The testing would be explained and you would be given the opportunity to ask any questions you might have. I have read and understand the above "Notice of Deemed Consent to HIV Blood Testing

Date: ________________________ Patient/Legal Representative: ____

Witness:: ____