

BUTLER RD.
1202 E. BUTLER RD.
GREENVILLE, S.C. 29607
PHONE (864) 627-3800
FAX (864) 672-2654

ALLERGIC DISEASE AND ASTHMA CENTER, P.A.
C. ALLEN BRUCE, M.D. EMMANUEL U. SARMIENTO, M.D. NEIL L. KAO, M.D.

MEMORIAL MEDICAL
7 MEMORIAL MEDICAL DRIVE
GREENVILLE, S.C. 29605
PHONE (864) 295-2492
FAX (864) 295-2494

SPARTANBURG
3020 REIDVILLE RD.
SPARTANBURG, S.C. 29301
PHONE (864) 699-4870
FAX (864) 699-4874

PATIENT INFORMATION

DATE _____

Patient _____
Last First Middle

Address _____
Street

City State Zip

Home Phone _____

Work Phone _____

Social Security No. _____

Marital Status _____

Person Responsible for bill _____

Address _____ Home Phone _____

Work Phone _____

In Case of Emergency Contact: _____ Phone _____

Referring Physician's Name _____

Address _____ City _____ State _____ Zip _____

Primary Physician's Name _____

Address _____ City _____ State _____ Zip _____

PRIMARY INSURANCE COVERAGE

Insured Name _____ DOB _____

ID# _____ Group # _____

Company _____

Address _____

City State Zip Phone No.

SECONDARY INSURANCE COVERAGE

Insured Name _____ DOB _____

ID# _____ Group # _____

Company _____

Address _____

City State Zip Phone No.

FOR MINOR CHILDREN, PLEASE COMPLETE THE FOLLOWING:

Father _____

Address _____

Phone No. _____
Home Work

Mother _____

Address _____

Phone No. _____
Home Work

Father's Birthdate _____ SS# _____

Employer _____

Employer's Address _____

Mother's Birthdate _____ SS# _____

Employer _____

Employer's Address _____

I understand that I may be subject to charges for appointments not cancelled 24 hours in advance.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to Allergic Disease and Asthma Center, P.A. of the Medical Benefits, if any, otherwise payable to me for their service. I also authorize Allergic Disease and Asthma Center, P.A. to release any information acquired in the course of treatment for insurance purposes. I understand that responsibility for payment lies solely with me.

Signed: _____