MASA
MIDWEST ALLERGY SINUS ASTHMA sc

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Patient Information

Name:_____ DOB:_____ Sex:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: Home/Cell_____ Work:_____

E-Mail:_____

Responsible Party:_____ Relationship:_____ Phone:_____

Address:_____ City:_____ Zip:_____

Emergency contact:_____ Phone:_____

Primary Care Physician _____

Other Physicians:_____

Whom may we thank for referring you:_____

The physicians at Midwest Allergy Sinus Asthma, SC conduct clinical research trials through our affiliated Sneeze, Wheeze and Itch Associates. May We notify you of studies in which may be of interest and/or benefit to you? _____YES, _____NO

Insurance information

All co-pays and self-pay services are expected to be paid the day of service

*Primary Insurance:*_____ *Secondary Insurance:*_____

*Subscriber:*_____ *Subscriber :*_____

*Subscriber DOB:*_____ *Subscriber DOB:*_____

*Social Security #:*_____ *Social Security #:*_____

*ID#:*_____ *Group#:*_____ *ID#:*_____ *Group#*_____

*Copay $:*_____ *Co-Ins $:*_____ *Copay $:*_____ *Co-Ins $:*_____

I, the undersigned, have my insurance with the above insurance(S) and assign directly to the Midwest Allergy Sinus Asthma, SC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature *Date*