REGISTRATION FORM

Jennifer Collins, MD Allergy, Asthma, Immunology

Date:_____

Full Name: _____ SS #: _____

Address: _____
Street City State Zip

Home #: _____ Cell #: _____ Work #: _____

Sex: ❑ M ❑ F Primary Phone: ❑ Home ❑ Cell ❑ Work

Birth Date: _____ Age: _____ ❑ Single ❑ Married ❑Widowed ❑ Divorced

Email: _____ Join our email list? ❑ Yes ❑ No

Primary Doctor's Name: _____ Phone #: _____

Address: _____
Street City State Zip

Referred by: ❑ Dr_____ ❑ Family ❑ Friend ❑ Internet ❑ Insurance

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Employer: _____ Occupation: _____

Address: _____
Street City State Zip

INSURANCE INFORMATION

Relationship to Subscriber: _____

Address: _____
(If different) Street City State Zip

Subscriber's SS #: _____ Birth Date: _____ Phone #: _____

Primary Insurance: _____

Policy #: _____ Group #: _____

Additional Insurance: _____

Policy #: _____ Group #: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone # : _____ Fax #: _____

Address: _____
Street City State Zip

IN CASE OF EMERGENCY

Contact: _____Relationship to patient: _____ Phone #: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize *Gramercy Allergy & Asthma* or insurance company to release any information required to process my claims.

_____ _____
Patient/Guardian Signature *Date*