LAWRENCE J. NEWMAN, M.D. ♦ STEVEN A. SUTTON, M.D. ♦ JOHN A. ECKMAN, M.D.

ALLERGY & ASTHMA ASSOCIATES, INC. *513-793-6861*
10597 Montgomery Rd., Suite 200, Cincinnati, OH 45242
7144 Office Park Dr., West Chester, OH 45069

Date: _____ Physician being seen:_____

Patient's Legal Name: _____

Name you would like to be called: (Nickname) _____ Social Security #: _____

Date of Birth: _____ Sex: M or F Marital Status: Married Single Divorced Separated (Circle One)

Address: _____ Apt./Unit#: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ Cellular/Pager #: (_____) _____

Father's Name: (If patient is under 18)_____ DOB _____

Mother's Name: (If patient is under 18) _____ DOB _____

Employer: _____ Work Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address (if available): _____ How did you hear about us? _____

Referring Physician: _____ Primary Care Physician: _____

Address: _____ Address: _____

Pharmacy Name: _____ Pharmacy Phone #: (_____) _____

Nearest Friend or relative: _____ Phone #: (_____) _____

Relationship to Patient: Spouse Parent Grandparent Daughter Son Friend Other: _____
(Circle one)

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: Name of Insurance Company: _____

Is this Insurance an H.S.A.? _____ (Yes or No) Effective Date: _____

Insurance ID#: _____ Insurance Phone Number: _____

Name of Primary Person Insured: _____ Employer: _____

Social Security #: _____ Date of Birth: _____ Phone #: (_____) _____

Relationship to Cardholder: Self Spouse Parent Grandparent Other: _____ (Circle One)

Secondary Insurance: Name of Insurance Company: _____

Is this Insurance an H.S.A.? _____ (Yes or No) Effective Date: _____

Insurance ID#: _____ Insurance Phone Number: _____

Name of Primary Person Insured: _____ Employer: _____

Social Security #: _____ Date of Birth: _____ Phone #: (_____) _____

Relationship to Cardholder: Self Spouse Parent Grandparent Other: _____ (Circle One)

Is this injury related? ☐ Yes ☐ No Date of injury: _____

Type of injury: ☐ Motor Vehicle ☐ At Work ☐ Pedestrian ☐ Animal Bite ☐ Other: _____

Do you have injury related coverage information other than health insurance? ☐ Yes ☐ No

May we discuss your healthcare with someone other than yourself? ☐ Yes ☐ No

If yes, whom may we discuss it with: _____

Relationship to Patient: Spouse Parent Grandparent Daughter Son Friend Other: _____
(Circle one)

May we leave test results, etc. on your answering machine if you are not available? ☐ Yes ☐ No

Statement to permit payment of Medicare/insurance benefits to provider, physicians, and patient.

I authorize you to give me reasonable and proper medical care by today's standards. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers or other health insurance company any information needed for this or a related Medicare claim or other health insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accept assignment. I authorize and direct the health insurance company to issue payment check(s) directly to the physician(s) rendering the covered services. I understand it is mandatory to notify the health provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply. I hereby claim the amount of indemnity specified in my contract with my health insurance company. I realize that I am responsible for all coinsurance, deductibles, and non-covered services billed to me by either entity listed above.

Signature: _____ Date: _____