

# Allergy & Asthma Care Center

2510 Limestone Parkway  
Gainesville, GA 30501

922 Gainesville Hwy. Suite 115  
Buford, GA 30518

Phone (770)534-9933 Fax (770)534-8999

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Nickname: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Daytime Phone #: \_\_\_\_\_

\_\_\_\_\_ Evening Phone #: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ SS#: \_\_\_\_\_

Marital Status of Pt: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_ Spouse Daytime #: \_\_\_\_\_

Parent/Guardian Name and daytime phone # (if Pt is a minor): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Ph#: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Ph# \_\_\_\_\_

Employer Address: \_\_\_\_\_

Name, address and phone number of Physician who referred you to us: \_\_\_\_\_

How did you hear about us? Radio Newspaper Friend Doctor Other \_\_\_\_\_ Name of friend \_\_\_\_\_

Names of family members that are patients here: \_\_\_\_\_

### **GUARANTOR INFORMATION** (Person responsible for the bill if other than the patient)

Guarantor's Full Name: \_\_\_\_\_ Guarantor's DOB: \_\_\_\_\_

Mailing Address (if different from above): \_\_\_\_\_

Patient's relationship to Guarantor: \_\_\_\_\_ Guarantor's SS#: \_\_\_\_\_

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.  
PLEASE REVIEW IT CAREFULLY.**

Health Insurance Portability and Accountability Act of 1996 (HIPAA) The HIPAA law was designed to protect the privacy of patients. Our office pledges to protect your privacy at all times. Your private patient information will only be disclosed with your permission and a signed authorization form, unless otherwise stated.

We do need a way to contact you for appointment reminders, lab results and general nursing calls. We will leave a detailed message for appointment reminders but all other messages we will ask you to return our call.

Phone number where you can best be reached: \_\_\_\_\_ Can we leave a message for you at this number? Yes No

Please provide email address: \_\_\_\_\_

When is the best time to call? \_\_\_\_\_

(We will do our best to call during this time but we reserve the right to call outside of the times that you have listed.)

In some instances, your insurance carrier will request additional information from us. The registration form that you have previously signed says that it is fine for us to send them this information. We will continue to call in prescriptions to your pharmacy for your convenience. Pharmacies are required to adhere to the same privacy laws as physicians.

We reserve the right to make revisions as necessary. You will be provided with a revised copy of this letter if revisions are made.

Your signature on this form indicates that you have read and understand the information that it contains.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date