THE ALLERGY GROUP
OF SOUTHERN CALIFORNIA

18370 Burbank Blvd Suite 307
Tarzana CA 91356 • 818.996.6000

29525 Canwood Street Suite 250
Agoura Hills CA 91301 • 818.735.5555

Adult Registration

Name

LAST: _____ **FIRST**: _____ **M.I.**:_____

Date of Birth: _____ **Social Security Number**:_____

Sex: □ Male □ Female **Driver's License**: _____ **State Issued**: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed

In Case of Emergency Contact:_____ **Phone**: _____

Referred By: _____

Addresses

Home Address:

Street Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Home Phone: _____ **Cell Phone**: _____

Email Address: _____

Employer:_____

Occupation:_____ **Work Phone**:_____

Work Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Insurance

Primary Insurance

Name of Primary Insurance Co.:_____ **Phone**:_____

ID/Policy Number:_____ **Group Number**:_____

Subscriber/Insured: _____ **Relationship**:_____

Subscriber Date of Birth:_____ **Subscriber Social Security Number**:_____

Subscriber Employer Name:_____ **Subscriber Employer Phone**:_____

Secondary Insurance (if applicable)

Name of Primary Insurance Co.:_____ **Phone**:_____

ID/Policy Number:_____ **Group Number**:_____

Subscriber/Insured: _____ **Relationship**:_____

Subscriber Date of Birth:_____ **Subscriber Social Security Number**:_____

Subscriber Employer Name:_____ **Subscriber Employer Phone**:_____

Pharmacy Information

Name of Pharmacy:_____ **City**:_____

Phone:_____ **Fax**:_____

I, the undersigned, assign directly to **The Allergy Group of Southern California** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I will be required to present my health insurance card and driver's license to ensure coverage and identity. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Signature:_____ **Date**:_____

Patient Information ***(continued from page one)***

Patient Name:_____ Date:_____

Family History (Check if a family member has had any of the following):
(Allow M=mother, F=father, S=sibling, GM=grandmother, GF=grandfather, A=aunt, U=uncle)

- ☐ _____Allergies
- ☐ _____Anemia/Blood disorders
- ☐ _____Asthma
- ☐ _____Bladder/Kidney
- ☐ _____Cancer
- ☐ _____Deafness
- ☐ _____Diabetes before 50 yrs.
- ☐ _____Drug allergies
- ☐ _____Drug/alcohol abuse
- ☐ _____Ear Infections/PE Tubes
- ☐ _____Emotional/Behavioral
- ☐ _____Epilepsy or convulsions
- ☐ _____Eye or visual problems
- ☐ _____Heart attack/stroke before 50 yrs.
- ☐ _____Other Hearth problems
- ☐ _____Hereditary problems
- ☐ _____High blood pressure before 50 yrs.
- ☐ _____High cholesterol
- ☐ _____Immunity problems/HIV
- ☐ _____Learning problems/Attention span
- ☐ _____Liver Disease
- ☐ _____Mental Illness
- ☐ _____Mental Retardation
- ☐ _____Obesity
- ☐ _____Respiratory infections
- ☐ _____Stomach/GI
- ☐ _____Thyroid/Endocrine problems
- ☐ _____Tuberculosis
- ☐ _____Other_____
  _____

Family

Are patient's mother and father: ☐ Married ☐ Separated ☐ Divorced

If separated or divorced, what is the patient's custody status? _____

_____

If one or both of the parents are not living at home, how often does the child see that parent(s)?_____

_____

Are there siblings living away from home? ☐ No ☐ Yes (if yes, please state ages and where they are currently living):_____

_____

Current Medical History

Is patient having any medical problems? ☐ No ☐ Yes (if yes, please explain):_____

_____

Is patient generally in good health? ☐ Yes ☐ No (if no, please explain):_____

_____

Are immunizations up to date? ☐ Yes ☐ No (if no, please explain):_____

_____

Please list current medications:_____

_____

Does patient have any drug allergies? ☐ No ☐ Yes (if yes, please list):_____

_____

_____

Has patient had any past surgeries? ☐ No ☐ Yes (if yes, please explain):_____

_____

_____

Are there any other concerns you have regarding your child? ☐ No ☐ Yes (if yes, please explain):_____

_____

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Financial Policy and Patient Agreement

Our office is committed to providing excellent, affordable medical care. You have the right and responsibility of knowing the cost of your medical treatment. Although we bill your insurance company directly, you may be responsible for co-payment, co-insurance, deductible and non-covered amounts. Ultimately, it is your responsibility to make sure you are familiar with your plan. It is always a good idea to double check with your particular plan to ensure that the services rendered are covered by your plan. If you are unsure, you may decline the services. For your convenience, our office accepts personal checks, credit cards and cash. Please read the following carefully, as it outlines our financial policy.

It is important that insurance patients understand how insurance billing works. Insurance companies require us to break down every component of your office visit into universal, numerical procedure codes and charge for each code. The insurance companies will arbitrarily change, combine and disallow procedure codes and then apply their company's individual fee schedule. The result is the insurance company's determination of "reasonable and customary" changes, which is the amount they are willing to cover. The insurance company usually reduces the actual reimbursement further by the individual policy's annual deductible, co-payment or co-insurance.

This method of billing, designed by the insurance industry, forces us to bill at full price procedure codes that the insurance company will likely reduce, combine or simply deny. This system, in fact, has the insurance company determining our fees. If we have a contract with your insurance company, we write-off the amount over the "reasonable and customary" and bill you for your co-insurance and deductible. If we do not have a contract with your insurance carrier, you are responsible for that amount as well as any deductible and co-insurance amount.

We are required by all insurance carriers to collect from patients any deductible and co-payment or co-insurance amounts. In the unlikely event you stop payment, are notified of Non-Sufficient Funds or your account is turned over to Collections, you will be responsible for all related costs.

Patient Agreement:

I have read and understand **The Pediatric Group and/or The Allergy Group of Southern California** financial policy as outlined above. The following constitutes an agreement between the undersigned patient/guarantor and **The Pediatric Group and/or The Allergy Group of Southern California.**

In the event **The Pediatric Group and/or The Allergy Group of Southern California** agrees to seek payment initially from my insurance company, I request payment to be made directly to them of all medical benefits otherwise payable to me for services rendered. I understand any final obligations for payment are mine. I hereby consent to and authorize the performance of all treatments, and medical services by the physicians and staff, which they may deem advisable, and agree to pay all charges incurred by reason thereof. Any portions of my bill not paid by insurance, including services my insurance may determine "not medically necessary" are my responsibility and are due and payable upon demand. I hereby authorize **The Pediatric Group and/or The Allergy Group of Southern California** to release all information necessary to secure payments of benefits.

The Pediatric Group and/or The Allergy Group of Southern California charges a 1.5% service charge per month for balances remaining unpaid after 45 days.

Patient/Guardian Legal Name (please print clearly):_____

Patient/Guardian Signature:_____ **Date**:_____