Allergy & Asthma Specialists of Michigan

Angela M. Iacobelli, M.D.
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43417 Schoenherr Road
Sterling Heights, MI 48313

Phone: 586.981.0390
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www.aasmich.com

Patient Registration

Patient Name: _____ Date: _____/_____/_____
(First) (Middle) (Last)
Sex: M____F____ DOB: ____/____/____ Age: _____ Marital Status: (circle) S M W D

Address: _____
(Street) (City) (State) (Zip)
Telephone: Home_____Cell:_____Work:_____
Email address: _____
Employed by:_____ Employer Address_____
Occupation_____ Preferred method of contact: Phone____ Email____ Other_____
Primary Care Physician: _____ Phone: _____
Address: _____
Referred by: Physician____ Self____ Family _____Friend____ Internet____ Insurance Company___Other_____
Referred by: _____
(List name of the person who referred you; if referred by a doctor who is not your primary care doctor list name and address)
Emergency Contact: _____Phone:_____Relationship:_____

Insurance Information:

Primary Insurance: _____
Subscriber Name:_____Subscriber Date of Birth:_____
Relationship to patient: _____ Group #_____ Contract #_____
Subscriber Employer: _____

Secondary Insurance:_____
Subscriber Name:_____Subscriber Date of Birth:_____
Relationship to patient: _____ Group #_____ Contract #_____
Subscriber Employer: _____

Financial Authorization:

We participate and accept assignment of payment with most major insurance plans in the area. Even though we may submit insurance claims for you, your insurance coverage is a contract between you and your insurer and you are still responsible for payments and services regardless of the amount your insurance pays. If your insurance company requires an authorization or referral, it is the patient's responsibility to obtain this for the initial visit and for continuation of care.

I hereby authorize the office of Allergy & Asthma Specialists of Michigan to release any information necessary to process any insurance claim for services rendered. I hereby authorize payment from my insurance company or governmental payer to pay directly to Allergy & Asthma Specialists of Michigan for services rendered. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered.

Print Name/Signature_____Date_____
Print Name/Signature Patient/Parent/Guardian

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Patient Registration

For Pediatric Patients:

Who does the patient live with?_____Relationship to the Patient:_____
Mother/Guardian Name:_____Contact Phone:_____
Address :(if different than above):_____
Father/Guardian Name _____Contact Phone: _____
Address: (if different than above):_____

Permission to treat minor when parent/guardian not present

I, _____ the parent/guardian of_____,
give Asthma & Allergy Specialists of Michigan, permission to treat my child when not accompanied by a parent or guardian. This request shall be void upon written request.
Signature: _____ Date: _____