Longevity Physician Specialists: Allergy Division
REGISTRATION FORM

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PATIENT INFORMATION

Patient's Last Name: First: Middle:			Sex: ❑ Male ❑ Female	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?		Date of Birth: / /	Age:
Street address:	City:	State:	Zip Code:	

Please check best contact phone number below:

❑ Home Phone: ( )	❑ Work Phone: ( )	❑ Cell Phone: ( )
Preferred Language:	Ethnicity: Please Circle Hispanic \ Non-Hispanic	Race:

List your email address below to gain access to your Personal Medical Portal. You will be able to update your information, request prescription refills, request appointments, and contact our medical staff. **Email Address:** _____

Patients employment status: Active \ Retired \ Student	Employer:	Employer Phone:
Pharmacy Name:	Pharmacy location \ Phone:	
Chose clinic because/Referred to clinic by (please check one box):	❑Family ❑ Friend ❑Internet ❑Ad ❑Physician ❑ Insurance Plan Name:_____	
Referral Name: (If physician, please provide phone number)	Referring Physician's Number: ( )	
Primary Care Physician:	Primary Care Physician's Number: ( )	

INSURANCE INFORMATION

Policy holder's name:		Date of Birth: / /	Policy holder's employment status: Active \ Retired \ Student	
Insurance name:	❑ Check if address of policy holder is the same as above. If not, please provide the complete address below:			
Patient's relationship to policy holder:	❑ Self	❑ Spouse	❑ Child	❑ Other
Employer:	Employer Phone: ( )			

Secondary Policy/Policy holder's name:		Date of Birth: / /	Policy holder's employment status: Active \ Retired \ Student	
Insurance name:	❑ Check if address of policy holder is the same as above. If not, please provide the complete address below:			
Patient's relationship to policy holder:	❑ Self	❑ Spouse	❑ Child	❑ Other
Employer:	Employer Phone: ( )			

IN CASE OF AN EMERGENCY

Name of local friend or relative (not living at same address):	Relationship:	Home or Cell Phone: ( )	Work Phone: ( )

LPS will process insurance claim for my convenience. I understand that co-pays, deductibles and procedures not covered by my insurance are my responsibility. I understand that I am responsible for knowing my insurance benefits; however A&A Specialists will attempt to verify my coverage for charges on date of services. If insurance fails to reimburse for services recommended or provided despite these efforts, I am responsible for total bill whether the services are performed at our facility or an outside location. I will inform any changes regarding my insurance immediately. Any charges that result from failure to do so will be solely my responsibility. A&A Specialists reserves the right to charge patients a fee for late cancelation or no show appointments.

Responsible Party for Minors (Please list the Parent or Guardian that accompanied the child today)
Please be aware, if the responsible party was designated by a court order and is not present today, it is our office policy to request a copy of the court order from you.

Name:_____ Date of Birth:_____ Are you a patient of our office?: ❑ Yes ❑ No

Address:_____ Relationship to Patient_____

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