East Memphis Allergy & Asthma
Betty Mirro, M.D. Ashley Escue, M.D.

PATIENT INFORMATION (Please complete for patient being seen):

Name_____Male____Female____Race_____Birthday_____

Address_____City, State, Zip_____

Home Phone #_____Work /Cell Phone #_____

SSN #_____Married_____Single_____Divorced_____Widowed_____

Email address:_____

FOR MINORS ONLY:

Father's Name_____ Mother's Name_____

Address(if different)_____ Address(if different)_____

City_____State____Zip_____City_____State___Zip_____

Phone_____Cell_____Work_____ Phone_____Cell_____Work_____

Employer_____Employer_____

Emergency Contact (not living with you)_____

Phone #_____Work #_____Relation to patient_____

Name of your Primary Care Physician_____Phone #_____

Who referred you to our office?_____ ( ) Yellow Pages ( ) Internet ( ) Other_____

INSURANCE INFORMATION: MAY WE PLEASE MAKE A COPY OF YOUR CARD(S)?

PRIMARY INSURANCE

Name of Insurance Company_____Phone #_____

Address_____City, State, Zip_____

Policyholder_____I.D.#_____Group_____

Policyholder's Date of Birth_____SSN #_____

Name of Policyholder's Employer_____Effective Date_____

SECONDARY INSURANCE

Name of Insurance Company_____Phone #_____

Address_____City, State, Zip_____

Policyholder_____I.D.#_____Group_____

Policyholder's Date of Birth_____SSN #_____

Name of Policyholder's Employer_____Effective Date_____

I authorize release of any medical information necessary to process this claim. I also authorize Medicare and/or any other insurance payment of medical benefits to EMAA for services provided to me. I understand that I am financially and totally responsible to EMAA for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverage's are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney fees. I authorize EMAA to provide medical treatment to me and/or the patient listed above.

PATIENT/RESPONSIBLE PARTY'S SIGNATURE_____Date_____