



SOUTHWEST ALLERGY AND ASTHMA CENTER, P.A.

Medical Center Office
7711 Louis Pasteur Drive
Suite 901-905
San Antonio, Texas 78229
Telephone: (210) 616-0690

Stone Oak Office
155 Sonterra Blvd.
Suite 101
San Antonio, Texas 78258
Telephone: (210) 494-0690

Westover Hills Office
3903 Wiseman Blvd.
Suite 202
San Antonio, Texas 78251
Phone: (210) 767-0690

Patient Information

Date: _____ Referred By: _____

Last Name _____ First _____ Middle _____

Street Address _____ City _____ State _____

Zip Code _____ Home# _____ Work# _____ Cell# _____

Maiden Name _____ Date of Birth _____ Age _____

SS# _____ Martial Status _____ S _____ M _____ Other _____

Employer _____ Occupation _____

Drivers License# _____

Spouse/Parent/Guardian Name _____ Date of Birth _____ Age _____

SS# _____ Work# _____ Cell# _____

Employer _____ Occupation _____

****EMERGENCY CONTACT _____ PHONE () _____**

**** Insurance Information ****

Name of Primary Insurance _____ Co-Pay Amount _____

Policy# _____ Group# _____

Insurance Claims Address _____

Insurance Phone Number _____

Insured Last Name _____ Insured First Name _____

Policyholder SSN# _____

Relationship to patient _____ Date of Birth _____

Insured Address (if different from patient's) _____

Insured Employer _____

Name of Secondary Insurance _____ Co-Pay Amount _____

Policy# _____ Group# _____

Insurance Claims Address _____

Insurance Phone Number _____

Insured Last Name _____ Insured First Name _____

Policyholder SSN# _____

Relationship to patient _____ Date of Birth _____

Insured Address (if different from patient's) _____

Insured Employer _____

Other Family Members Seen in Our Office

Last Name _____ First Name _____ MI _____ DOB _____ Relationship _____

Last Name _____ First Name _____ MI _____ DOB _____ Relationship _____

PAYMENT POLICY:

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY BALANCE THAT ACCUMULATES AND AGREE TO PAY ANY BALANCE DUE AFTER INSURANCE HAS PAID OR RESPONDED.

AUTHORIZATION OF PAYMENT:

I HEREBY AUTHORIZE S W ALLERGY & ASTHMA TO RELEASE MEDICAL INFORMATION CONCERNING MY EXAMINATION AND/OR TREATMENT FOR INSURANCE PURPOSES AND TO RECEIVE DIRECT PAYMENT FOR MEDICAL BENEFITS PAYABLE TO ME FOR SERVICES RENDERED.

SIGNED: _____ DATE: _____