

ALLERGY & ASTHMA CARE OF INDIANA/PATIENT REGISTRATION

Date _____

Name _____ Male or Female Single Married Other
Last First Middle

Address _____ City _____ State _____

Zip _____ Home Phone# () _____ Cell Phone # () _____

Social Security# _____ DOB _____ EmailAddress: _____

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____ Work Phone# () _____

If patient is a minor, provide Mother's Name _____ Father's Name _____

PRIMARY INSURED PARTY INFORMATION

Name _____ Male Female DOB _____
Last First Middle

SS# _____ Relationship to Patient _____ Home Phone# () _____

Address _____ City _____ State _____ Zip _____

Employer _____ Address _____

City _____ State _____ Zip _____ Work Phone# () _____

SECONDARY INSURED PARTY INFORMATION

Name _____ Male Female DOB _____
Last First Middle

SS# _____ Relationship to Patient _____ Home phone # () _____

Address _____ City _____ State _____ Zip _____

Employer _____ Address _____

City _____ State _____ Zip _____ Work Phone # () _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone# _____ Cell# _____

PRIMARY CARE PHYSICIAN

Name _____ Address _____ Phone# _____

REFERRED BY

Name _____ Address _____ Phone # _____

Allergy and Asthma Care of Indiana

Garrick Hubbard, MD ▪ Jenny Casburn, NP-C ▪ Maggie Blettner, NP-C
Main Phone 317 708 2839 ▪ Fax 317 708 2877

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Limited Patient Authorization for Disclosure of Protected Health Information to an Individual

Please print all information. Form must be signed and dated yearly in order to be valid.

Patient Name: _____ DOB: _____

Please indicate below if it is okay to leave protected health information via voicemail(s) on your home and cell

Yes No or Please indicate phone number(s) _____

I authorize Allergy and Asthma Care of Indiana to disclose or provide protected health information about me to the individuals listed below:

Name: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Name: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Name: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Information to be disclosed may include medical or financial information such as lab or x-ray results, current health record, previous/other provider health records, and/or payment information.

Or (please specify) only the following information: _____

This authorization will expire at the end of the calendar year of your last signature below. You must renew or submit a new authorization after the expiration date to continue the authorization.

You have the right to terminate this authorization at any time. You must notify us in writing if you decide to terminate the expiration prior to the end of the signed calendar year.

You are in no way obligated to sign this form in order to receive medical treatment.

We have no control over the person(s) you have listed to receive your protected health information and cannot be responsible for how they choose to use or share the information once it is disclosed.

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

You have a right to receive a copy of signed authorizations upon request.