Texas Allergy Center
Jane J. Lee, M.D., P.A.
Board Certified in Allergy, Asthma, and Immunology
Board Certified in Internal Medicine

Patient: _____ SS Number: _____
Last First MI

Sex: ( ) M ( ) F Age: ____ DOB: _____ Marital Status: ( ) M ( ) D ( ) S ( ) W

Home Address: _____
City State Zip Code

Electronic Mail Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Work Address: _____
City State Zip Code

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient:_____

DOB: _____SS#: _____Employer:_____

Insurance Company: _____ ID#: _____

Group#: _____ Benefit Verification Phone#: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient:_____

DOB: _____SS#: _____Employer:_____

Insurance Company: _____ ID#: _____

Group#: _____ Benefit Verification Phone#: _____

In Case of Emergency, Notify: _____
Relationship: _____
Work Phone: _____ Cell Phone: _____

RELEASE OF INFORMATION: I hereby authorize the physician and/or supplier to release any information required to process this claim and claims for any future treatment unless rescinded by me in writing.

Date: _____ Signature: _____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Jane J. Lee, M.D., P.A. for services performed. I also understand that any and all services (including allergy extract) that are not covered by the insurance will by my responsibility.

Date: _____ Signature: _____