Allergy & Asthma Center at Waxahachie

Scot Laurie, M.D.

Date_____ Patient Acct # _____

Patient's Last Name_____ First Name_____
Address_____ City_____ State_____ Zip _____
Sex_____ Age_____ Date of Birth _____ SS#_____
Drivers License #_____ Home Phone_____
Work Phone _____ Cell Phone_____
Email Address_____ Fax_____

Name of Responsible Party (if other than patient) _____
Address (if different) _____City_____ State_____
Home Phone _____Cell Phone _____ Work Phone_____
Name of Nearest Relative not living with you_____
Relationship _____ Home Phone _____Work Phone_____
Please list other members of your family that are patients here & their relationship: _____
Emergency Contact _____ Phone #_____
Cell#_____Work#_____
Pharmacy Info- Location_____
Pharmacy Telephone #_____

Who recommended our office? _____
What is your medical coverage? _____

HMO EPO/POS PPO INDEMNITY MEDICARE

PRIMARY INSURANCE INFORMATION
ID #_____

Insurance Company Name:_____ Group # _____
Claims billing address _____
Insured Name _____ Relationship to patient _____
Male Female SS#_____ DOB of insured _____
Employer Name: _____ Address: _____
City _____ State_____ Zip_____

Secondary Insurance Company _____Group#_____
Claims Address _____City _____ State_____ Zip_____
Insured _____ Relationship to Patient _____ Male Female
SS#_____ DOB _____ Employer _____

Scot Laurie, MD, P.A.

Allergy & Asthma Center at Waxahachie

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this office's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I undersand that I am entitled to receive a copy of your Notice of Privacy Practices.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Scot Laurie M.D.

Patient Record of Disclosure:

We have your permission to disclose medical information/results about yourself or minor patient to the following people. If left blank, we will not be able to advise anyone or your medical status or address questions they ask on your behalf.

Patient's name:_____

DOB:_____

1. Name:_____ Relationship_____
2. Name:_____ Relationship_____
3. Name:_____ Relationship_____
4. Name:_____ Relationship_____

Should any information change, it is your responsibility to advise of your change and you will need to complete a new disclosure. Otherwise, we will not be held responsible for releasing information to a party you wish to no longer access your information.

Patient Signature:_____Date:_____