ALL SEASONS ALLERGY, ASTHMA AND IMMUNOLOGY CENTER

PEDIATRIC PATIENT INFORMATION

PATIENT'S NAME ______________________________ NICKNAME ______________

DATE OF BIRTH ____/____/____ SEX: FEMALE MALE HOME PHONE ______________

ADDRESS ______________________________

CITY ______________ STATE ______ ZIP ______ EMAIL ______________

SCHOOL ATTENDING ______________________________

PRIMARY CARE PHYSICIAN ______________________________

FATHER'S NAME ______________________________ DATE OF BIRTH ____/____/____

ADDRESS ______________________________

CITY ______________ STATE ______ ZIP ______

EMPLOYED BY ______________ HOME PHONE ______________

OCCUPATION ______________ CELL PHONE ______________

BUSINESS ADDRESS ______________ WORK PHONE ______________

CITY ______________ STATE ______ ZIP ______

MOTHER'S NAME ______________________________ DATE OF BIRTH ____/____/____

ADDRESS ______________________________

CITY ______________ STATE ______ ZIP ______

EMPLOYED BY ______________ HOME PHONE ______________

OCCUPATION ______________ CELL PHONE ______________

BUSINESS ADDRESS ______________ WORK PHONE ______________

CITY ______________ STATE ______ ZIP ______

NAME OF PERSON LEGALLY RESPONSIBLE? ______________________________

(IF PATIENT IS A MINOR, PLEASE LIST PARENT LISTED AS PRIMARY CARD HOLDER)

NOTE: IF YOU HAVE A SECONDARY INSURANCE CARRIER, PLEASE GIVE OUR OFFICE THE ADDITIONAL INFORMATION.

GENERAL CONSENT FOR MEDICAL TREATMENT:

I, KNOWING THAT I AM SUFFERING FROM A CONDITION REQUIRING DIAGNOSTIC, MEDICAL OR SURGICAL TREATMENT DO HEREBY VOLUNTARILY CONSENT TO SUCH PROCEDURES AND CARE AND TO SUCH MEDICAL SURGICAL OR OTHER SERVICES UNDER THE GENERAL AND SPECIFIC INSTRUCTIONS OF STEPHEN E. MILES, M.D., HIS ASSISTANTS OR HIS DESIGNEE AS IS NECESSARY IN HIS JUDGEMENT. I ALSO ACKNOWLEDGE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OF TREATMENTS OR EXAMINATION BY STEPHEN E. MILES, M.D.

FINANCIAL RESPONSIBILITY AGREEMENT:

ALLERGY EVALUATION INCLUDING SKIN TESTING AND/OR ANY OTHER SERVICES PERFORMED BY THIS OFFICE ARE SUBJECT TO PAYMENT IN FULL AT TIME OF SERVICE. AS A COURTESY TO OUR PATIENTS, OUR OFFICE WILL FILE ON YOUR INSURANCE PROVIDED ALL INSURANCE INFORMATION AND FORMS ARE FURNISHED. ALL OTHER ARRANGEMENTS FOR PAYMENT MUST BE MADE IN ADVANCE. PLEASE GIVE THE OFFICE A TWENTY-FOUR HOUR NOTICE TO CANCEL AN APPOINTMENT. AS A COURTESY TO OUR OTHER PATIENTS, IT IS IMPORTANT THAT YOU BE ON TIME FOR YOUR APPOINTMENT. I HAVE READ THE ABOVE OFFICE POLICY REGARDING PROFESSIONAL FEES AND SERVICES AND ACCEPT RESPONSIBILITY FOR PAYMENT OR SERVICES RENDERED.

NO SHOW POLICY:

A $40.00 CHARGE WILL BE ASSESSED FOR ALL MISSED OR RESCHEDULED APPOINTMENTS WITHOUT A 24-HOUR NOTICE. THREE MISSED APPOINTMENTS WILL RESULT IN A DIVORCE OF THE PATIENT/DOCTOR RELATIONSHIP.

SIGNATURE ______________________________ **DATE** ______________