Asthma & Allergy Physicians of RI, Inc.
Patient Information Sheet

Full Name: _____ Address: _____

Ste/Apt: _____ City: _____ State: _____ Zip: _____ Postal Code _____

Telephone: (Home) _____ (Work): _____ (Cell): _____

Race: _____ Ethnicity: _____ Language: _____

Date of Birth: _____ Gender_____ SS#: _____ Email Address: _____

Employed By: _____ Spouse, Parent, Guardian's Name: _____

Primary Care Physician: _____ Referring Physician: _____

Primary Insurance: _____ Insurance Number: _____

Effective Date: _____

Insured's Name: _____ Date of Birth: _____ SS# _____

Secondary Insurance: _____ Insurance Number: _____

Effective Date: _____

Secondary Insured's Name: _____ Date of Birth: _____ SS# _____

Insured's Employer: (Primary) _____ (Secondary): _____

Emergency Contact: _____ Phone: _____ Relationship: _____

CONSENT FOR HEALTHCARE OF MINOR:

Because my son/daughter is a minor (less than eighteen years of age and primarily supported by parent or guardian), I understand and agree that he/she may be evaluated and/or treated by Asthma & Allergy Physicians of Rhode Island staff if I am not present to give consent. This may include but not necessarily be limited to physical exams, skin testing, allergy injections and the prescription of medications in my absence. This agreement will be in effect until revoked by me in writing.

Signature of parent or guardian: _____ Date: _____

BILLING PROCEDURE

The office participates with most insurance carriers in the state as well as several carriers out of state. If you have health coverag with any of these carriers, we will automatically bill them for their contracted portion of your care. In most other situations we will provide you with a copy of our encounter form, which you may then submit to the carrier for reimbursement. This encounter form has the information required by most insurance companies. Your signature is required in all cases where we will be submitting on your behalf to the carrier.

Signature: _____ Date: _____

How did you hear of this office: (Please circle one or more)

Physician's name: _____ Friend or Yellow Pages

Asthma & Allergy Physicians of Rhode Island, Inc.

Research Division

AAPRI Clinical Research Institute
470 Tollgate Rd.
Warwick, RI 02886

One of the ways Dr. Z stays on top of the "state of the art treatments" is his involvement in clinical research trials. 90% of our patients who participate request to be involved in additional trials. You may fit criteria for a trial. Answering yes to "participating" does not commit you to participating; it only allows us to contact you if you are eligible.

Would you be interested in participating in a research study:

Yes or No (Please circle one)

(*Answering yes does not commit you to any studies*)

You may contact me if you feel I may be eligible to enroll as a study patient:

Signature: _____ Date: _____

_____
Print patient's name & DOB

I would rather not be approached about any studies even if I were eligible:

Signature: _____ Date: _____

_____
Print patient's name & DOB