Patient Registration Form

Timber Lane Allergy & Asthma Associates, P.C.

Patient Information

Patient Information:

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Referring Provider, if applicable:	Date of Birth:	Sex: ○ Male ○ Female ○ Transgender	
Marital Status: ○ Divorced ○ Married ○ Single ○ Other_____	Employer Name:		

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:		First Name:
Date of Birth:	Phone:	Relationship to Patient:
Address of Person Responsible:		
City/State/Zip:		

Secondary Parent (if patient is under the age of 18), that is not the policyholder on the insurance:

Last Name:		First Name:
Date of Birth:	Phone:	Relationship to Patient:
Address:		
City/State/Zip:		

Additional Information:

Email Address:

Race (please select): ○ White ○ American Indian or Alaska Native ○ Asian ○ Hispanic ○ Black or African American ○ Native Hawaiian or Pacific Islander ○ Other ○ Decline	Ethnicity (please select one): ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline

Preferred Language (please select one): ○ English ○ Bosnian ○ Indian (including Hindi & Tamil) ○ Sign Language ○ Spanish ○ Russian ○ Other

Other offices you would like visit notes sent to:

Provider Name: Name of office:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Insurance ID# Insurance Group #	Insurance ID# Insurance Group #
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder: