INSURANCE & NEW PATIENT INFORMATION

Patient:_____ **DOB:**_____/_____/_____

Patient (H) #:_____**(W) or (C)**_____

Patient Address:_____

_____

Referred by Dr. _____ **Complaint:** _____

Allergy Testing: Yes NO **Medicines:** _____

Primary Cardholder: _____ **DOB:** _____/_____/_____

Employer:_____ **Relationship:** _____

Insurance Company: _____

Insurance ID: _____ **PPO HMO EPS POS Other**_____

Group #_____ **Government Insurance Yes or NO**

Insurance Phone # for customer service: _____

########## **Office use only below** ##########

Date of Appointment: _____**Time of Appointment:** _____

Contact Person:_____ **Date:**_____

Effective Date:_____**Type of Coverage: Family Ind. Group Self Ins.**

Life Time Maximum: _____ **OOP**_____

Deductible: $_____**(**_____ **met for yr** _____**) Co-Ins:**_____/_____**%**

Insurance Network:_____ **Is Dr. Miles a provider? Y N**

Referral Required ____**no**_____**verbal**_____**yes**____ **PCP** _____

Office Visit for specialist: _____

Allergy Testing: (95004) _____

Allergy Serum: (95165) _____

Are allergy shots a co-pay event? (95115) _____

Pulmonary Function Test PFT (94010 or 94060) _____

Insurance Claims Address: _____

_____

_____