Charlottesville Allergy and Respiratory Enterprises, PLLC
1532 Insurance Lane, Charlottesville, Virginia 22911

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Diplomate, American Board of Allergy and Immunology

PATIENT REGISTRATION

Name: _____ Date: _____
Last First Middle

Address:_____
City:_____ State: _____ Zip: _____
Home Phone: ( ) _____ Work Phone: ( ) _____
Date of Birth: _____ Age: _____ Gender: ☐M ☐F
Social Security #: _____ (Note: If the Social Security # is not provided, you may be required to pay for the visit in full. Please see our staff for details.)
Marital Status: ☐S ☐M ☐W ☐D
Email Address: _____
Do you grant CARE, PLLC permission to email appointment confirmation, newsletters & patient education materials: ☐Yes ☐No
Employer: _____
Employer's Address: _____
Spouse's Name: _____ Spouse's Employer: _____
Work Phone: _____
Primary Care Physician's Name & Practice Location:
_____
Do you consent to CARE, PLLC sending recommendations regarding your medical condition to your Primary Care Physician: ☐Yes ☐No

INSURANCE INFORMATION

Primary Insurance Name: _____ Card Copied: ☐Yes ☐No
Policy Holder's Name: _____ Date of Birth: _____
Social Security #: _____ Relationship to Patient: _____
Policy Holder's Employer: _____
Policy Identification #: _____ Group #: _____
Secondary Insurance Name: _____ Card Copied: ☐Yes ☐No
Policy Holder's Name: _____ Date of Birth: _____
Social Security #: _____ Relationship to Patient: _____
Policy Holder's Employer: _____
Policy Identification #: _____ Group #: _____

EMERGENCY CONTACT (FOR NOTIFICATION IN CASE OF AN EMERGENCY)

Name: _____ Relationship: _____
Address: _____ Phone #: _____
Employer: _____ Work #: _____

CONSENT TO TREATMENT AND RESPONSIBLE PARTY STATEMENT

I consent to examination and treatment of my medical condition(s) by CARE, PLLC physicians. I also authorize CARE, PLLC to furnish information to insurance carrier(s) concerning my condition and/or treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____

Patient's Signature Date

OR

_____

Responsible Party's Signature Date

_____

Responsible Party's Social Security # Responsible Party's D.O.B.