

2550 Niles Road
St. Joseph, MI 49085
Phone (269) 429-1085
Fax (269) 429-2202

Allergy, Asthma & Sinus Center

Paul S. Judge, M.D.

*Fellowship Trained in Allergy and Immunology
Pediatrics and Adult*

951 Pipestone Rd.
Benton Harbor, MI 49022
Phone (269) 925-0323
Fax (269) 925-1146

Welcome to our Practice!

Personal & Family Information

Today's Date: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____ Age: _____

Sex: ____ Race: _____ Marital Status: _____ SS# ____ - ____ - ____ Driver License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: (____) ____ - ____ Cell: (____) ____ - ____ Work # (____) ____ - ____

Employer's Name & Address: _____

Spouse's Name (if avail.): _____ Date of Birth: ____/____/____

Spouse's Employer: _____ Spouse's Work #: (____) ____ - ____

Personal Physician: _____ Address & Phone #: _____

Referring Physician (if avail.): _____ Address & Phone #: _____

Emergency Contact: _____ Relationship to Patient: _____

Phone #: (____) ____ - ____ Cell #: (____) ____ - ____ Work # (____) ____ - ____ other: (____) ____ - ____

Insurance Information

Name of Insured Policy Holder: _____ Relationship to patient: _____

Subscriber's SS#: ____ - ____ - ____ Subscribers Date of Birth: ____/____/____

Policy Holder Employer's Name and Address: _____

Primary Insurance Company: _____ Secondary Insurance Company: _____

How did you learn about us? Referred by doctor, Insurance Company Directory, Family, Friend, Co-Worker, Internet

If phone book, which one: _____ other: _____

I authorize Allergy, Asthma & Sinus Center the following:

- Use of this form as authority to submit claims and receive payment from my health insurance companies.
- Release any medical information necessary to my insurance companies to process claims.
- Use a copy of this authorization in place of the original.

Payment Policy: We accept assignment on many insurance companies upon verification of benefits. If we are unable to verify coverage at the time of your visit, we will request you pay your bill in full. If you are uninsured or do not bring your insurance card or want to file your own insurance then you are expected to make full payment for the services received. **Your co-pay and/or deductible are payable on the day services are provided.** Insurance is a contract between you and your insurance company and it is your responsibility to know and understand it. However, we will be happy to assist you in any way to assure that you receive your best benefits. Because of the complexities of insurance filing, we offer the service of filing for you as a courtesy to our patients. If your insurance company has not paid in 45 days (by law 30 days) then you will be billed for the remaining balance, which will be due immediately. Please remember you are responsible for timely payments for all services provided regardless of insurance coverage or status. We will greatly appreciate you calling your insurance company if your bill is not being paid on time or in full.

Date: ____/____/____

Signature (Parent or Guardian's if a minor): _____ Relationship: _____