

The Allergy Center at Brookstone
New Patient Appointment Request

This line only for staff /clinic use Appointment Date _____ Appointment Time _____ Doctor _____

Patient or Parent /Guardian

Reason for Requesting Appointment (Check all that apply) Hayfever _____ Sinus problems _____ Asthma _____

Skin Disorder _____ Other _____

Primary Care Provider's (PCP) Name _____ Phone # _____

Referral Source (Check One) PCP _____ Self _____ Other (Name) _____

Patient Information

Patient (Legal) Name _____ SSN _____

Marital Status _____ Sex _____ Race _____ Birthdate _____

Address _____

City/ State _____ Zip Code _____

Home Phone # _____ Alternate Phone # _____ Best Phone # _____

Employer _____ Work Phone _____

If Patient is a child, please complete the following:

Parent's Name _____ SSN _____

Marital Status _____ Sex _____ Birthdate _____

Parent's Address _____

City/State _____ Zip Code _____

Home Phone # _____ Alternate Phone # _____ Best Phone # _____

Employer _____ Work Phone # _____

Comments _____

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Insurance Information

Note: Please list all policy's starting with the primary policy. If you do not know which insurance plan is your primary, please let us know and we will investigate for you. It is considered insurance fraud if you chose to use the secondary plan as primary.

Primary Insurance Information

Primary Insurance Company Name _____
Insurance Claims Address _____
City/State _____ Zip Code _____
Insurance Group # _____ Policy/Member # _____
Customer Service Phone # (on insurance card) _____
Person Insured _____ Relationship to Patient _____
Insured's Address _____
City/State _____ Zip Code _____
Work Phone # _____ Birthdate _____
Name of Employer _____

Secondary Insurance Information

Primary Insurance Company Name _____
Insurance Claims Address _____
City/State _____ Zip Code _____
Insurance Group # _____ Policy/Member # _____
Customer Service Phone # (on insurance card) _____
Person Insured _____ Relationship to Patient _____
Insured's Address _____
City/State _____ Zip Code _____
Work Phone # _____ Birthdate _____
Name of Employer _____

For Staff use: Date Insurance Verified _____ By _____ Policy Effective Date: _____
Active: Y N Referral Required: Y N Co-pay _____ Deductible _____ Ded Met Y N