

REGISTRATION
(PLEASE PRINT)

AUSTIN ALLERGY ASSOCIATES
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3303 Northland Drive, Suite 301
Austin, TX 78731
512-458-9191 / 512.458-2330 fax

Date _____ Home Phone (_____) _____ Cell Phone (_____) _____

PATIENT INFORMATION

Name _____ Social Security _____
LAST NAME FIRST NAME MIDDLE INITIAL

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____
 Married Widowed Single
 Divorced Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (_____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec.# _____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____

Policy#/Subscriber ID _____ Group# _____

Name of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (_____) _____

Insurance Company _____

Policy#/Subscriber ID _____ Group# _____

Name of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and or my dependent(s), have insurance coverage with _____ and assign directly to Austin Allergy Associates, Dr. Vaughan and or Dr. Dyer, all insurance benefits if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of my all insurance submissions. The above named doctors may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I also acknowledge that I have received a copy of Austin Allergy Associates Notice Regarding Privacy of Personal Health Information.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent Guardian or Personal Representative

Relationship to Patient