Allergy & Asthma Center at Waxahachie/Mansfield

OFFICE (972)923-9200 FAX (972)923-9201

Scot Laurie, M.D.

Date_____ Patient Acct # _____

Patient's Last Name_____ First Name_____
Address_____ City_____ State_____ Zip _____
Sex_____ Age_____ Date of Birth _____ SS#_____
Drivers License #_____ Home Phone_____
Work Phone _____ Cell Phone_____
Email Address_____ Fax_____

Name of Responsible Party (if other than patient) _____
Address (if different) _____City_____ State_____
Home Phone _____Cell Phone _____ Work Phone_____
Name of Nearest Relative not living with you_____
Relationship _____ Home Phone _____Work Phone_____
Please list other members of your family that are patients here & their relationship: _____
Emergency Contact _____ Phone #_____
Cell#_____Work#_____
Pharmacy Info- Location_____
Pharmacy Telephone #_____

Who recommended our office? _____
What is your medical coverage? _____

HMO EPO/POS PPO INDEMNITY MEDICARE

PRIMARY INSURANCE INFORMATION
ID #_____
Insurance Company Name:_____ Group # _____
Claims billing address _____
Insured Name _____ Relationship to patient _____
Male Female SS#_____ DOB of insured _____
Employer Name: _____ Address: _____
City _____ State_____ Zip_____

Secondary Insurance Company _____Group#_____
Claims Address _____City _____ State_____ Zip_____
Insured _____ Relationship to Patient _____ Male Female
SS#_____ DOB _____ Employer _____