STAAMP

SOUTH TEXAS ALLERGY & ASTHMA MEDICAL PROFESSIONALS
10447 Highway 151
San Antonio, TX 78251-4551

Office: (210) 616-5385
Fax: (210) 647-1012

JOHN P. DICE, M.D.
BOARD CERTIFIED ALLERGY & IMMUNOLOGY

ERIKA GONZALEZ-REYES, M.D.
BOARD CERTIFIED ALLERGY & IMMUNOLOGY

MARK C. STAHL, D.O.
BOARD CERTIFIED ALLERGY & IMMUNOLOGY

JOEL A. REYES, D.O.
MEDICAL DIRECTOR

PATIENT INFORMATION SHEET

PLEASE PRINT DATE: _____

PATIENT'S NAME _____ DOB _____ M / F
ADDRESS_____ HOME PHONE (____) _____
CITY_____ STATE _____ ZIP_____
BEST NUMBER TO REACH YOU DURING THE DAY (_____) _____
WORK PHONE _____ CELL PHONE _____
EMAIL ADDRESS _____
MARITAL STATUS _____ ETHNIC ORIGIN _____
2 EMERGENCY CONTACT PHONE#s _____
RELATIONSHIP TO PATIENT _____
PATIENT MEDICATION ALLERGIES OR NONE _____
REASON FOR VISIT _____
PRIMARY CARE PHYSICIAN _____ PHONE_____
REFERRED BY _____ PHONE _____

INSURANCE INFORMATION:
INSURANCE CARRIER _____
POLICY HOLDER_____ DOB _____ GROUP ID _____
MEMBER NUMBER _____ EMPLOYER NAME _____
SECONDARY INSURANCE _____ GROUP ID _____
POLICY HOLDER_____ DOB _____ MEMBER NUMBER _____
EMPLOYER _____
PERSON RESPONSIBLE FOR ACCOUNT_____
SS#_____ **DRIVER'S LICENSE #**_____
RELATIONSHIP TO PATIENT _____ PHONE NUMBER_____
ADDRESS (if different from patient) _____

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF MEDICAL INFORMATION

I _____, HEREBY AUTHORIZE THE RELEASE OF MY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMIITTED ON BEHALF OF MYSELF AND/OR DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY PHYSICIAN TO SUBMIT CLAIMS FOR BENEFITS FOR SERVICES RENDERED WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND/OR DEPENDENTS, AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM. I _____, HEREBY AUTHORIZE MY INSURANCE COMPANY(IES) TO PAY AND HEREBY ASSIGN DIRECTLY TO SOUTH TEXAS ALLERGY AND ASTHMA MEDICAL PROFESSIONALS ALL BENEFITS PAYABLE FOR SERVICES PERFORMED.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. AS A COURTESY SOUTH TEXAS ALLERGY AND ASTHMA MEDICAL PROFESSIONALS WILL FILE MY INSURANCE CLAIM FOR ME. CO-PAY AND DEDUCTIBES ARE DUE AT TIME OF VISIT. IF MY INSURANCE COMPANY DOES NOT PAY WITHIN 90 DAYS, I WILL BE BILLED FOR SERVICES RENDERED. IF AN INSURANCE CHECK IS LATER RECEIVED FROM MY INSURER, ANY OVERPAYMENT WILL BE REFUNDED TO ME.

Signature / Guardian _____ DATE _____