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Edgar Rojas, MD
Consulting Physician

Francis E. Neuzil, Jr., Ph.D., APRN-BC
Board Certified Adult Medicine

The Allergy, Sinus and Asthma Family Health Center
Personal Information

Today's Date: _____

Last name _____ First name_____

Mailing address _____ Apt # _____

City _____ State _____ Zip code _____

Home phone (___)_____ Work (___)_____ Cell (___)_____

Social Security # _____ D.O.B. _____ Sex: M/F_____

Emergency Contact: _____ Phone# (___)_____

Employer Name: _____

Employer Phone: _____ Contact Person: _____

PRIVACY AGREEMENT

We respect your right to privacy. Be assured we make every effort to protect your confidential medical records. A copy of our privacy policies are available upon request, your signature below affirms you were told about our privacy policy.

Signed: _____ Date: _____

Please read carefully

In consideration for services rendered by Allergy, Sinus & Asthma Center, I hereby agree to release any information requested as needed by my insurance benefits. I further agree to be solely responsible for, and pay any balance my insurance company doesn't pay.

Signature of person responsible for paying bill: _____