LISA SULLIVAN, M.D.

Specializing in Pediatric and Adult Allergy, Asthma and Immunology

Date: _____ E-mail: _____ Text#:_____

Patient: _____
Last Name First Name Middle Initial

Responsible Party (if a minor) _____

Address: _____
Street City State Zip

Home Phone: _____ Cell or Alternate Phone: _____ Patient Age: _____

Patient Marital Status: __ S __ M __ W __ S __ D Patient Date of Birth: ____/____/____ Patient Sex: M___ F___

Emergency Contact: _____ Emergency Phone #: _____

Primary Care Provider:_____Phone#:_____

Referring Physician: _____
Name Address Phone

Referring Physician will receive a consultation letter for your initial visit. If none, please write none.

Referring Friend: _____List family members seen in this facility: _____
Name Name

Name of Spouse / Parent: _____

Guarantor for Account: _____
Name Address SS#

Guarantor Employer: _____
Name Address Phone

Primary Insurance Company: _____ Group & ID #'s: _____

Claims Mailing Address: _____

Policy Holder Name: _____ Date of Birth: _____

Secondary Insurance Company: _____ Group & ID #'s: _____

Claims Mailing Address: _____

Policy Holder Name: _____ Date of Birth:_____

We will require a copy of <u>All</u> valid insurance cards to submit your claims.

Agreement and Release

I, the undersigned, have insurance coverage with _____ and assign directly to Dr. Sullivan all
Name of Insurance Company
medical 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 the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Patient / Guarantor Signature Date

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