GEIST CENTER FOR ALLERGY, ASTHMA IMMUNOLOGY, PC
8150 Oaklandon Road, Suite 119 Indianapolis, Indiana 46236
t e l (317)826.5440 fax (317)826.5463 www. g e i s t a l l e r g y.com

PATIENT INFORMATION			GUARANTOR INFORMATION (Person Responsible for Bill)		
Patient's last name	First		Last Name	First Name	
Home Address (Street, Apt#)			Home Address (Street, Apt#)		
City, State & Zip	SS#		City, State & Zip	SS#	
Date of Birth	Email:		Date of Birth	Email:	
Home Phone:	Work Phone:	Cell Phone:	Home Phone:	Work Phone:	Cell Phone:
Family Dr:		Family Dr Phone:	Language:	Ethnicity:	Number Preferred:
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed			**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Sex ☐ Male ☐ Female			**Sex** ☐ Male ☐ Female		
Patient Employer			Guarantor Employer		

INSURANCE INFORMATION (Please give your insurance cards to the receptionist.)

Primary Insurance Name			Secondary Insurance Name		
Insured Name	Insured DOB	Relationship to patient	Insured Name	Insured DOB	Relationship to patient
ID Number	Group Number		ID Number	Group Number	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient	Home phone	Work phone

I hereby consent to the physician and other persons acting under her direction and supervision to administer examination, treatments, and other procedures as are deemed necessary.

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 insurance submissions. In addition, I hereby designate Geist Center for Allergy, Asthma & Immunology, PC and its employees and agents as my representative to file grievances and to represent me in the in accordance with the Indiana Code, Title 27, Chapters 8 & 13. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand this authorization will remain in effect until revoked in writing. I hereby agree to pay Geist Center for Allergy, Asthma & Immunology, PC the charges for all medical services rendered. In the event that I fail to pay the fees agreed, I understand I will be responsible for all attorney fees, court costs and collection fees that may result from my failure to pay, to which may be added prejudgment and/or post-judgment interest at the current legal rate.

I acknowledge receipt of this facility's Notice of Privacy Practices. (Available anytime on-line or in our offices)

Patient/Guardian signature ______________________ _Date_ ____________

Consent to Treat Minor

I, the undersigned, am the legal guardian of ____ a minor, do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of Geist Center for Allergy, Asthma & Immunology, PC licensed under the provisions of the laws in the state of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide the authority and power to render care, which the aforementioned provider in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Guardian signature ______________________ _Date_ ____________