Paul F. Detjen, M.D.
Adult and Pediatric Asthma and Allergy

Confidential Patient Information

Today's Date: _____

-PATIENT INFO-

Patient Name (Last) (First) (MI)				Age
Date of Birth	Sex M F	Marital Status M S W D O	Address (Street) (City) (State) (Zip Code)	
Home Phone ( )	Work Phone ( )	Mobile Phone ( )		
Email	(If Child) Mother's/Father's Name			
Employer	Occupation			
Referred By:	Other Family Members Seen By Us:			

-PCP-

Primary Care Physician / Referring Physician

Name: _____ Phone: _____

Address: _____ Fax: _____

-INSURANCE-

Insurance Company Name:
Effective Date:

If you are covered under the policy of a spouse, partner, parent or legal guardian, please tell us about them.

-SUBSCRIBER-

Name (Last) (First) (MI)			Relationship
Date of Birth	Address (Street) (City) (State) (Zip Code)		
Home Phone ( )	Work Phone ( )	Mobile Phone ( )	
Employer	Occupation		

- EMERGENCY CONTACT -

Name	Relationship
Home Phone ( )	Work Phone ( )	Mobile Phone ( )

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE NAMED PROVIDER FOR PROFESSIONAL SERVICES RENDERED, AND AUTHORIZE PURSUIT OF INSURANCE APPEALS ON PATIENT BEHALF IF NEEDED (ERISA 1974).

SIGNED_____ DATE _____

I ACKNOWLEDGE THAT I HAVE BEEN GIVEN AN OPPORTUNITY TO REVIEW THE KENILWORTH MEDICAL ASSOCIATE'S PATIENT PRIVACY NOTICE. **(HIPAA)**

SIGNED_____ DATE _____