COVENANT
Allergy & Asthma Care

Susan P. Raschal, D.O.

DIPLOMATE American Board of Allergy & Immunology

Date_____

ADULT PATIENT INFORMATION

Referring Physician_____ Phone_____

Primary Care Physician_____ Phone_____

PATIENT_____
First Middle Last Preferred Name

Phone_____ Phone_____ Fax_____ E-mail_____
Home Cell

Address_____
Street City ST Zip Code

S.S. #_____ Age_____ Birth Date_____

Male Female African American Caucasian Hispanic Asian American Indian

Married Single Other

EMPLOYER_____ Business Phone_____

Address_____
Street City ST Zip Code

SPOUSE'S NAME_____ S.S. #_____ DOB: _____

Employer_____ Business Phone _____

Address_____
Street City ST Zip Code

PRIMARY PHARMACY_____ Phone_____

SECONDARY PHARMACY_____ Phone_____

EMERGENCY INFORMATION (friend or relative at different address):

Name_____ Phone_____

Address_____
Street City ST Zip Code

*****PLEASE NOTIFY OUR STAFF IF YOU WOULD LIKE PRAYER TODAY*****

1350 Mackey Branch Drive, Suite 114 • Chattanooga, TN 37421 • Phone: (423) 468-3267 • Fax: (423) 468-3270
www.covenantallergy.com

INSURANCE INFORMATION

1. _____
Name of Insurance | Primary Insured's Name | Primary Insured's DOB

_____
Policy or I.D. # | Group #

2. _____
Name of Insurance | Primary Insured's Name | Primary Insured's DOB

_____
Policy or I.D. # | Group #

Medicare #_____ GA/TN Medicaid # _____

HOW DID YOU INITIALLY HEAR ABOUT US?

Doctor _____ Family/Friends _____ TV_____ Public Event _____ Yellow Pages _____ Website _____

Other (please list) _____

PAYMENT IS DUE WHEN SERVICES ARE RENDERED!

1. AUTHORIZATION TO TREAT AND RELEASE INFORMATION: I hereby authorize Covenant Allergy & Asthma Care to release any social and medical information acquired in the course of my examination or treatment for the purpose of filing for insurance benefits and other financial coverage.

   Date_____ Signature of Patient _____

2. AUTHORIZATION TO PAY: I hereby authorize payment of medical benefits directly to Covenant Allergy & Asthma Care. I understand that I am financially responsible for the charges not covered by this assignment and, that should the account be referred to a collection agency, I agree to pay reasonable attorney fees and collection expenses.

   Date_____ Signature of Patient _____

IN ORDER FOR ALLERGY TESTING TO BE MOST ACCURATE, PLEASE DO NOT TAKE ANY ANTIHISTAMINES FOR AT LEAST 5 DAYS BEFORE YOUR APPOINTMENT.