



Susan P. Raschal, D.O.

DIPLOMATE American Board of Allergy & Immunology

Date _____

CHILD 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

PRIMARY PHARMACY _____ Phone _____

SECONDARY PHARMACY _____ Phone _____

FATHER'S NAME _____
First Middle Last S.S.# Birth Date

Address _____ Phone _____
Street City ST Zip Code

Employer _____ Business Phone _____

MOTHER'S NAME _____
First Middle Last S.S.# Birth Date

Address _____ Phone _____
Street City ST Zip Code

Employer _____ Business 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

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 Parent/Guardian _____

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 Parent/Guardian _____

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