BETH LOUIE, M.D.
DIPLOMATE OF AMERICAN BOARD
OF ALLERGY & IMMUNOLOGY

PATIENT REGISTRATION

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Date _____ Patient Name _____ (FIRST / MI / LAST) Patient # _____

SS#/SIN _____ ☐ Male ☐ Female Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Do you prefer to receive calls at your: ☐ Home ☐ Work ☐ Cell Phone

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient or parent/guardian's employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or parent/guardian's name _____ Date of Birth _____ Work Phone _____

If patient is a student, name of school/college _____ City _____ State/Prov. _____

Whom may we thank for referring you ? _____

Person to contact in case of emergency _____ Phone _____

Name of Insured_____Relationship to Patient_____

Birthdate_____SS#_____ Name of Employer_____

Work Phone_____Address of Employer_____

Insurance Company_____

ID #_____Group#_____

Driver's license#_____

Do you have any additional insurance: _____Yes _____No If yes, complete the following:

Name of Insured_____Relationship to Patient_____

Birthdate_____SS#_____Name of Employer_____

Work Phone_____Address of Employer_____

Insurance Company_____

ID#_____Group#_____

Patient's Authorization to Release Medical Information & Claim Payment:
I hereby authorize the above physician(s) to release any information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance.

_____ _____
Date Patient (Parent / Guardian)

I hereby authorize and direct my insurer to issue payment check(s) for benefits due me for the services rendered by the above physician(s) to be made directly to him/her. Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered.

_____ _____
Date Patient (Parent / Guardian)

Medicare Beneficiary Signature on File:
I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services (CSM) and healthcare financing administrations or their intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Beth Louie, M.D.

_____ _____
Date Medicare Beneficiary or Appointed Representative