Wolff Allergy & Asthma
Fisher Building
3011 West Grand Boulevard, Suite 210
Detroit, MI 48202
Office: (313)-871-7572
Fax: (313)-871-7573

DEMOGRAPHIC INFORMATION

FIRST NAME: _____ **MI:** _____ **LAST NAME:** _____

DATE OF BIRTH: _____ **SEX: MALE** ☐ **FEMALE** ☐ **OTHER** ☐_____

BILLING ADDRESS_____

APARTMENT NUMBER: _____ **CITY:** _____ **STATE:** _____ **ZIPCODE:**_____

PRIMARY PHONE NUMBER: _____ ☐**CELL** ☐ **HOME** ☐ **WORK**

PRIMARY EMAIL ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP:**_____

EMERGENCY CONTACT PHONE NUMBER: _____

***IF MINOR---NAME OF LEGAL GUARDIAN:**_____

PERSON FINANCIALLY RESPONSIBLE FOR PATIENT: ☐ **Self** ☐ **LEGAL GUARDIAN**

PRIMARY INSURANCE

NAME OF INSURED (Last Name, First Name, Middle Initial) _____

RELATIONSHIP TO PATIENT ☐ **Self** ☐ **LEGAL GUARDIAN**

INSURED'S ADDRESS (if different from patient above) _____

INSURED'S I.D. NUMBER: _____

INSURED's POLICY GROUP NUMBER: _____

INSURANCE PLAN NAME OR GROUP NAME:_____

INSURED'S DATE OF BIRTH (if different from patient above) _____

SECONDARY INSURANCE

NAME OF INSURED (Last Name, First Name, Middle Initial) _____

RELATIONSHIP TO PATIENT ☐ **Self** ☐ **LEGAL GUARDIAN**

INSURED'S ADDRESS (if different from patient above) _____

INSURED'S I.D. NUMBER: _____

INSURED's POLICY GROUP NUMBER: _____

INSURANCE PLAN NAME OR GROUP NAME:_____

INSURED'S DATE OF BIRTH (if different from patient above) _____

AUTHORIZATION & ATTESTATION

I hereby assign to WolffAllergyAsthma PLLC any insurance or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned by contractual arrangement, payment to the practice will be made by any insurance. I acknowledge that I am responsible for any co-payments and deductibles. These amounts are due at the time services are rendered. I understand that in the event that services rendered are not covered by my insurance, I will accept financial responsibility for all services provided to me.

Printed Name: _____

Signature: _____ Date: _____