JEFFREY S. HALLETT, M.D.
Diplomate, Am. Board of Allergy & Immunology

PATIENT REGISTRATION

Today's Date:_____ Please tell us how you heard about our clinic:_____
(Doctor / Pharmacist / Friend / Phone Book / Internet, Etc.)

PATIENT INFORMATION

FULL Name _____
Address:_____
City:_____ State:____ Zip:_____
Date of Birth:_____ Age:_____
Married ❑ Single ❑ Widowed ❑ Divorced ❑
Home Phone Number:_____
Social Security Number: _____
Occupation:_____
Employer:_____
Employer Address: _____
Work Phone Number: _____
Cell Phone Number:_____

SPOUSAL INFORMATION

Full Name:_____
Address:_____
City:_____ State:____ Zip:_____
Date of Birth: _____
Home Phone Number:_____
Occupation: _____
Employer:_____
Employer's Address:_____
Work Phone Number:_____
Cell Phone Number: _____

IF THE PATIENT IS A MINOR OR A STUDENT

Father's Name:_____
Address:_____
City:_____ State:____ Zip:_____
Home Phone Number:_____
Father's Occupation:_____
Father's Employer:_____
Address:_____
Work Phone Number: _____
Cell Phone Number:_____

Mother's Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone Number:_____
Mother's Occupation:_____
Mother's Employer:_____
Address:_____
Work Phone Number: _____
Cell Phone Number:_____

EMERGENCY INFORMATION

In case of emergency, please contact (list relative or friend not living with you):
Name:_____
Address:_____
City:_____ State:____ Zip:_____
Home Phone Number:_____
Work Phone Number:_____
Relationship:_____

INSURANCE INFORMATION

Please present your insurance card to be copied.
Insured's Name:_____
Insurance Co.:_____
Address:_____
_____
City: _____State: ____ZIP:_____
Phone Number:_____
Insured's Date of Birth:_____
Insured's SSN#:_____
Policy or ID #:_____
Group #: _____
MEDICARE #:_____
_____

AUTHORIZATION: I authorize Jeffrey S. Hallett, M.D. to release any medical information necessary to process this claim; I authorize the doctor to apply for benefits on my behalf for services rendered and assign payment of these benefits to the doctor; and I permit a copy of these authorizations to be used in place of the original. I further understand that I am financially responsible for all charges whether or not covered by my insurance, and I agree to pay all bills incurred for medical and professional services.

✓ Signature:_____ Date:_____