Allergic & Asthmatic
COMPREHENSIVE CARE OF NEW JERSEY
Your home for focused one-on-one solutions

Eric S. Applebaum, M.D., FACAAL, Medical Director
3799 Route 46 East, Suite 205, Parsippany, NJ 07054-1101 ◆ Telephone (973) 335-1700

Patient Information

Last Name: _____ First Name _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Date of Birth: _____ Sex: Male Female Marital Status: S M D W

Social Security #: _____-_____-_____ Ethnicity: _____

Primary Language: _____ Email Address: _____

Student: Yes No If yes, school name: _____

Employer Name: _____

Address: _____

Work Phone: ( ) _____-_____ Ext. _____

Occupation: _____

Primary Care/Family MD Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: ( ) _____-_____

Referred to be seen by: _____

Insurance Information

Primary Insurance Company Name: _____

Identification# _____ Group#: _____

Subscriber: _____ Subscribers Birth date: _____

Sex: Male Female Relationship to Patient: Self Spouse Parent

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Social Security #: _____-_____-_____

Employer Name: _____

Secondary Insurance Information: Relationship to Patient: Self Spouse Parent

Primary Insurance Company Name: _____

Identification# _____ Group#: _____

Subscriber: _____ Subscribers Birth date: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Social Security #: _____-_____-_____

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Please complete the appropriate authorizations:

1. I authorize the release of medical information when necessary to process insurance claims.

   Signature: _____ Date: _____

2. I hereby agree to pay my account as services are provided. If for any reason there is a balance owing my account, I agree to pay promptly upon receipt of the monthly statement.

   Signature: _____ Date: _____

3. For Medicare Insurance: I request that payment for authorized Medicare benefits be made either to me or on my behalf to Allergic & Asthmatic Comprehensive Care of NJ, PA for any services furnished to me by that physician. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

   Signature: _____ Date: _____

4. For CHAMPUS/CHAMPVA Insurance: I request that payment of authorized benefits be made either to me or on my behalf to Allergic & Asthmatic Comprehensive Care of NJ, PA, for any services furnished me by that physician. I authorize any holder of medical information about me to release to OCHAMPUS and its agents any Information needed to determine these benefits or the benefits payable for related services.

   Signature: _____ Date: _____