Adult and Pediatric
Allergy, Asthma, and Immunology
Sergei Belenky MD

AHN PEDIATRICS
Pediatric Alliance

Patient Information

Patient First Name	Patient Last Name	Mi	Birthdate	Gender

Race	Primary Language	Ethnicity
		hispanic nonhispanic

Patient Address	City	State	Zip Code

Home phone	cell phone	email

Employer (or student)	Employer Address (or school district)	main phone number

PCP (primary doctor)	PCP phone number	PCP Address

Whom were you referred by?

Responsible party (if patient less than 18)

First Name	Last Name	Relationship to patient	Phone

Birthdate	address (if different)	City	State	Zip

Primary Insurance Information

Policyholder First Name	Policyholder Last Name	Birthdate	Gender

Policyholder's Home Address If different from patient)	City	State	Zip

Policy (insurance) Name	Policy Number	Group Number	Co Pay	Effective Date

Employer	Employer Address	main phone number	Cell phone

Authorization for Treatment

I hereby consent to diagnostic/medical treatment for myself or the above named minor patient deemed advisable by a physician of Pediatric Alliance (PA), as well as any assistant, designee or employee of PA. I understand that this treatment may include tests, examinations and emergency treatment. I request payment of medical benefits be made to PA. I authorize the release of any medical or other info necessary to process the claims for myself or the above named minor patient. PA offers a wide variety of services. Some or all of these services may not be covered under MY specific health plan. I acknowledge receipt of Pediatric Alliance "Notice of Privacy Practices" and Financial Policies. I have read, understand, and agree to follow the policies. As per the NOPP, I understand that I am partcipating in ClinicalConnect Health Information Exchange unless I sign the specific "opt-out" form. I understand and agree to these policies.

Patient or Parent signature_____ Date:_____

Print first and last name: _____

PLEASE PUT SECONDARY INSURANCE ON BACK

Secondary Insurance Information				
Policyholder First Name	Policyholder Last Name	Birthdate	Gender	
Policyholder Address		City	State	Zip
Policy Name	Policy Number	Group Number	Co Pay	Effective Date
Employer	Employer Address	main phone number	Cell phone	

file=forms permissions/patient information