Carlos J. Piniella, M.D., F.A.C.A.A.I.

Diplomat American Board of Adult and Pediatric Allergy Asthma, and Immunology

NEW UPDATE

PATIENT INFORMATION - Please Print

Patient's Last Name _____ First _____ Middle Initial _____

Social Security Number _____ Date of Birth _____ Age _____ Sex: Male Female

Address _____ Apt# _____

City _____ State _____ Zip _____

Primary Phone _____ ❑ Home ❑ Work ❑ Cell Alternate Phone _____ ❑ Home ❑ Work ❑ Cell

Email Address _____

Marital Status (check one) ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated

Employment Status (check one) ❑ Full Time ❑ Part Time ❑ Retired ❑ Other Student: ❑ Full Time ❑ Part Time

Employer _____ Occupation _____

Employer Address _____

Spouse / Parent Name: Last _____ First _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____ Phone _____

SSN _____ Date of Birth _____ Employer _____

Is this person the Insurance Policyholder? ❑ Yes ❑ No

How were you referred to this office? ❑ Physician ❑ Friend ❑ Family ❑ Insurance ❑ Internet ❑ Other

Referring Physician _____

Address _____ Phone _____

Primary Care Physician (if different) _____ Should we send notes to this doctor? ❑ Yes ❑ No

Address _____ Phone _____

Name of Family Members who are Patients Here / Relationship _____

Preferred Pharmacy _____ Phone _____

Address or Cross Street _____

Primary Insurance Company Name _____

Policy ID # _____ Insurance Address _____

Group # _____ Telephone _____

Subscriber's Name _____ Subscriber's Employer _____

Subscriber's Date of Birth _____ Subscriber's Relation to Patient: ❑ Self ❑ Spouse ❑ Other

Secondary Insurance Company Name _____

Policy ID # _____ Insurance Address _____

Group # _____ Telephone _____

Subscriber's Name _____ Subscriber's Employer _____

Subscriber's Date of Birth _____ Subscriber's Relation to Patient: ❑ Self ❑ Spouse ❑ Other

Assignment of Insurance Benefits:

I hereby authorize Dr. Carlos J Piniella M.D. and Office Staff, to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for payment of any amounts not covered by my insurance.

_____ _____

Patient's Signature Date Patient's Name (Please Print)

_____ _____

Parent or Legal Guardian's Signature Date Parent/Legal Guardian's Name (Please Print)

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR THE RECEPTIONIST.
PAYMENT FOR PROFESSIONAL SERVICES IS DUE AND PAYABLE WHEN SERVICE IS RENDERED.