Kenilworth Medical Associates
Adult and Pediatric Asthma and Allergy

Patient Registration

Date ___________________

-PATIENT INFO-

Patient Name (Last) (First) (MI)			Date of Birth	Age
Sex	Marital Status M S W D O	Address (Street) (City) (State) (Zip)		
Gender Identity if applicable Pronouns		Mobile phone Home	Work Other	
Email			Mother's / Father's names (if child)	
Employer			Occupation	
Referred by			Other family seen by us	

-PROVIDERS-

Primary Care Provider:____ Phone _________________________

Address:____ Fax ____________________________

Referring Provider:____ Phone _________________________

Fax ___________________________

-INSURANCE-

Insurance Company	Effective Date
Other details	

-SUBSCRIBER-

Name (Last) (First) (MI)			Relationship
Date of Birth	Address (Street) (City) (State) (Zip)		
Mobile ( )	Work ( )	Other ( )	
Employer	Occupation		

- EMERGENCY CONTACT -

Name		Relationship
Mobile ( )	Work ( )	Other ( )

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE NAMED PROVIDER FOR PROFESSIONAL SERVICES RENDERED, AND AUTHORIZE PURSUIT OF INSURANCE APPEALS ON PATIENT BEHALF IF NEEDED (ERISA 1974).

HIPAA: I ACKNOWLEDGE THAT I HAVE BEEN GIVEN AN OPPORTUNITY TO REVIEW THE KENILWORTH MEDICAL ASSOCIATE'S HIPAA PATIENT PRIVACY NOTICE.

SIGNED ____ DATE ______________________________