ALLERGY AND ASTHMA ASSOCIATES, Inc.

Christina M. Abraham, MD

Patient's name _____ Date_____ MR# _____

Date of birth _____ Age _____ Social Security #: _____

Address _____City_____State_____Zip_____

Home phone _____ Cell phone _____ Email: _____

Sex male / female Race_____ Marital Status _____ Employer/Occupation _____

Patient's Employer _____ Work phone _____ ext ____

Parent or Guardian's Names (if Minor) _____ Employers of parents _____

Address (If different from patient's) _____

Spouses name _____ Employer _____

Spouse's work phone _____ ext _____ Spouse's social security #_____

In case of Emergency Contact _____ Phone # _____

Family Physician (PCP) _____ Referred by _____

Person Responsible for Payment _____ Relationship _____

Please give a copy of the insurance card to the secretary for us to photocopy.

Primary holder on insurance: Name _____ SS# _____ DOB:_____

Please read before signing

A copy of the Notice of Privacy Practices is posted for review. Please sign below.

Date _____ Signed _____

I hereby authorize Allergy and Asthma Associates, Inc to release information to my insurance company. I hereby assign and direct payment to Allergy and Asthma Associates, Inc. of the benefits herein specified and otherwise payable to me but not to exceed the doctor's regular charges for this treatment or surgical procedures. I understand I am financially responsible to the corporation for charges/charged amounts not covered by this agreement.

Date _____ Signed _____

Virginia State law provides that when a healthcare worker is exposed to the body fluids of another person in a manner which may transmit human immunodeficiency virus (HIV-the virus that causes AIDS), such as an accidental needle stick, the patient shall be deemed to have consented to the testing for HIV and to the release of the results to the exposed person and to the local health department.

Date _____ Signed _____

By becoming a patient of Allergy and Asthma Associates, Inc. and presenting myself for appointment with the physicians or nurse practitioners, I consent and authorize treatment by the qualified care providers of Allergy and Asthma Associates, Inc. Qualified care providers include but are not limited to the physicians, nurse practitioners, phlebotomists, nurses, etc. I hereby agree that the care providers may examine me, perform non-invasive diagnostic tests and treatment to be performed.

Date _____ Signed _____