FREEDOM ALLERGY
ALLERGY SINUS AND COUGH CENTER

Ruchir Agrawal, MD
115 Genevieve Court, Peachtree City, GA 30269
1255 Johnson Ferry Road, Suite 2A, Marietta, GA 30068

Patient Registration Form

Today's Date:_____

Patient Name:_____ Patient Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email:_____ Gender: ☐ male ☐ female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Other

Preferred Language: ☐ English ☐ Other

Ethnicity:

☐ Hispanic/Latino ☐ Caucasian ☐ African American ☐ Asian ☐ Prefer not to answer

Employer:_____ Work Phone:_____

Social Security #:_____ Driver's License #:_____

Parent/Guardian Information
(if patient is under 18 years of age)

Parent/Guardian Full Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Employer:_____ Work Phone:_____

Social Security #:_____ Driver's License #:_____

Insurance Information

Primary Insurance Company:_____

Address:_____

City:_____ State:_____ Zip:_____

ID Number:_____ Group Number:_____

Guarantor Name:_____ Guarantor DOB:_____

Guarantor Employer:_____

Guarantor Relationship to Patient:_____

Secondary Insurance Company:_____

Address:_____

City:_____ State:_____ Zip:_____

ID Number:_____ Group Number:_____

Guarantor Name:_____ Guarantor DOB:_____

Guarantor Employer:_____

Guarantor Relationship to Patient:_____

Other Information

Pharmacy Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

Primary Doctor Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Doctor Phone:_____ Doctor Fax:_____

Referred by:_____

How did you hear about us? ☐ friend ☐ family ☐ doctor ☐ flyer ☐ community event

☐ internet search ☐ Facebook ☐ www.oit101.org

Financial Policy

I authorize the release of any information necessary to process claims. I request payment of benefits to Freedom Allergy. I understand I am financially responsible for charges not covered by insurance.

If your plan has a co-payment, deductible, and/or co-insurance, you will be expected to pay your portion prior to receiving any service including an office visit and/or immunotherapy. If you are on a high deductible plan, you will be required to pay a minimum of 50% at the time of service until we verify your deductible has been met.

Payment is due at the time of service unless prior financial arrangements have been made with our business office. Any account balance is expected to be paid in full prior to new services being rendered. Should it become necessary for Freedom Allergy to utilize the services of an outside collection agency, you may be held liable for collection agency fees and/or attorney fees.

I understand and agree if care at Freedom Allergy requires a primary care physician referral, it is my responsibility to see that the referral is current prior to receiving care at Freedom Allergy. If no referral is present in advance, I agree to pay for charges at the time of services.

I have read the above Freedom Allergy financial policy and understand my financial responsibility.

Patient/Responsible Party Signature:_____

Date:_____