

<b>PATIENT REGISTRATION (PLEASE PRINT)</b>	<b>CHART NUMBER</b>
--	---------------------

<b>PATIENT'S NAME</b>	<b>First</b>	<b>Initial</b>	<b>Last</b>	<b>HOME PHONE NUMBER</b>
-----------------------	--------------	----------------	-------------	--------------------------

<b>SEX</b>	<b>DATE OF BIRTH</b>	<b>MARITAL STATUS</b>	<b>SOCIAL SECURITY #</b>
Male Female		Single   Separated   Divorced Widowed   Married	

**ADDRESS STREET / APT. NUMBER**

---

**MAILING ADDRESS (IF DIFFERENT FROM HOME)**

---

<b>EMPLOYER'S NAME</b>	<b>ADDRESS</b>	<b>WORK NUMBER</b>
------------------------	----------------	--------------------

<b>PATIENT'S PRIMARY CARE PHYSICIAN</b>	<b>(ADDRESS)</b>	<b>(PHONE NUMBER)</b>
---	------------------	-----------------------

---

**RESPONSIBLE PARTY**

<b>PARENT/SPOUSE/SELF</b>	<b>RELATIONSHIP TO PATIENT (PLEASE CIRCLE)</b>
	Parent   Spouse   Guardian   Foster Parent   Other

<b>HOME ADDRESS</b>	<b>SOCIAL SECURITY NUMBER</b>
---------------------	-------------------------------

<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>	<b>HOME PHONE NUMBER</b>
-------------	--------------	-----------------	--------------------------

<b>EMPLOYER'S NAME</b>	<b>ADDRESS</b>	<b>WORK NUMBER</b>
------------------------	----------------	--------------------

<b>INSURANCE REGISTRATION (COPY OF INSURANCE CARD IS REQUIRED AT TIME OF SERVICE).</b> <b>*PLEASE NOTE: OUR OFFICE DOES NOT FILE CLAIMS FOR SECONDARY INSURANCE(S).</b>
--

<b>PATIENT'S PRIMARY INSURANCE</b>	<b>POLICY HOLDER'S NAME</b>
------------------------------------	-----------------------------

<b>ADDRESS</b>	<b>POLICY NUMBER</b>	<b>GROUP NUMBER</b>
----------------	----------------------	---------------------

**INSURANCE AUTHORIZATION AND ASSIGNMENT AGREEMENT**

I hereby authorize this office to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to the above named provider. In the event my account is referred for collection, I agree to pay all costs incurred in collecting the amount due including an additional amount of 33 1/3 percent as attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to other treating physicians and to my insurance company in order to determine insurance benefits to which I may be entitled. Either myself or my insurance company, at any time in writing, may revoke this authorization.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

\*\*\* Please turn over and complete the back \*\*\*

**Deemed Consent**

I understand that under Virginia law if, while examining or treating me, any person employed by or under the direction and control of Dr. Craig's office is directly exposed to my body fluids in a manner which may transmit HIV, Hepatitis B or Hepatitis C, I will be deemed to have consented to testing for HIV, Hepatitis B or Hepatitis C infection and to the release of the test results to the exposed person.

I have read the above consent. **PATIENT'S, PARENT'S, OR  
GUARDIAN SIGNATURE** \_\_\_\_\_

	Age	Serious Illness	Occupation
<b>Father</b>	_____	_____	_____
<b>Mother</b>	_____	_____	_____

**Other serious illness in family such as allergies, diabetes, stroke, heart attack or other inherited illnesses:**  
\_\_\_\_\_  
\_\_\_\_\_

**PATIENT'S PERSONAL MEDICAL HISTORY**

Hospitalization with Diagnosis	Operations	Injuries
_____	_____	_____
_____	_____	_____

Medical illnesses patient has had (circle and give date)

Chicken Pox \_\_\_\_\_ Pneumonia \_\_\_\_\_ Diabetes \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

Other medical illness (give name and date of illness) \_\_\_\_\_

Does patient have any drug or food allergies? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please list: \_\_\_\_\_

**AUTHORIZATION TO TREAT A MINOR CHILD**

The following person(s) listed below are able to bring my child into the office of Allergy & Asthma Center of Fredericksburg, Ltd. with my full approval to have care rendered by the physician and nurses for routine exams, allergy injections and emergency medical situations in my absence.

PATIENT'S FULL NAME \_\_\_\_\_

PATIENT'S DATE OF BIRTH \_\_\_\_\_

List person(s) authorized to bring in minor child & relationship

\_\_\_\_\_  
\_\_\_\_\_

(PRINT) Parent/Guardian \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

**EMERGENCY CONTACT (other than parent of spouse)**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

Allergy & Asthma Center of Fredericksburg, Ltd.  
SETH C. CRAIG, III, M.D. ANDREW S. KIM, MD  
1300 THORNTON STREET, SUITE 200  
FREDERICKSBURG, VIRGINIA 22401  
TELEPHONE: (540) 371-6810 FAX: (540) 371-9154

**Allergy and Asthma Center of Fredericksburg, Ltd**

Seth C. Craig III MD Andrew S. Kim MD

Diplomats of  
American Board of Pediatrics  
American Board of Internal Medicine  
American Board of Allergy & Immunology

College Heights Professional Building  
1300 Thornton Street Suite #200  
Fredericksburg, VA 22401  
Tel:(540) 371-6810 Fax:(540) 371-9154  
www.allergyasthmaDoctors.com

## IMPORTANT PLEASE READ

- **PLEASE NOTE THAT ALLERGY TESTING CAN TAKE UP TO 3 HOURS** AND WE HAVE RESERVED 3 HOURS IN OUR SCHEDULE FOR YOUR ALLERGY EVALUATION. TO AVOID POSSIBLE CANCELLATION CHARGES, PLEASE CALL US AT LEAST 24 HOURS IN ADVANCE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT.

- **IF YOU HAVE AN HMO INSURANCE:**

IT IS VERY IMPORTANT THAT YOU CONTACT YOUR PRIMARY CARE PHYSICIAN TO MAKE CERTAIN THAT WE GET YOUR REFERRAL BEFORE OR THAT YOU HAND-CARRY REFERRAL TO OUR OFFICE THE DAY OF YOUR APPOINTMENT. FOR YOUR OWN ASSURANCE, IF YOU DO NOT HAND-CARRY YOUR REFERRAL, WE ASK THAT YOU CALL OUR INSURANCE CLERKS TO VERIFY THAT WE HAVE RECEIVED YOUR REFERRAL AT LEAST (2) TWO DAYS BEFORE YOUR APPOINTMENT AT (540)899-6192. \*\*\*\* WE MUST STRESS THAT IT IS THE PATIENT'S RESPONSIBILITY TO ARRANGE THAT THE PROPER REFERRAL HAS BEEN RECEIVED BY OUR OFFICE FROM YOUR PCP.

IN THE EVENT THAT YOUR SPECIALIST RECOMMENDS ADDITIONAL VISITS AND/OR PROCEDURES NOT LISTED ON YOUR INITIAL REFERRAL, YOU MUST AGAIN CONTACT YOUR PCP TO PROCESS THE NEEDED REFERRALS.

- **PLEASE DO NOT TAKE ANY ANTI-HISTAMINES 3-5 DAYS PRIOR TO YOUR VISIT FOR ALLERGY TESTING.** ANTI-HISTAMINES ARE SUCH MEDICATIONS AS BENADRYL, CLARITIN, CLARINEX, ATARAX (HYDROXYZINE), ZYRTEC AND ALLERGRA. MANY OVER-THE-COUNTER COLD, COUGH, AND ALLERGY MEDICATIONS MAY ALSO CONTAIN ANTI-HISTAMINES. IF YOU ARE NOT CERTAIN WHETHER ANY OF YOUR MEDICATIONS CONTAINS AN ANTI-HISTAMINE, PLEASE CALL OUR OFFICE. ALSO IF YOU FEEL THAT YOU CANNOT DISCONTINUE YOUR ANTI-HISTAMINES FOR 3-5 DAYS PRIOR TO YOUR VISIT, PLEASE CALL US AS WELL.

- YOU DO NOT NEED TO STOP NASAL SPRAYS OR ASTHMA MEDICATIONS OR ANY OTHER MEDICATIONS FOR CONDITIONS SUCH AS HIGH BLOOD PRESSURE, CHOLESTROL, DIABETES, OR HEART DISEASE. PLEASE CONTINUE TO TAKE THESE IMPORTANT MEDICATIONS AS PRESCRIBED BY YOUR PHYSICIAN.

- THANK YOU FOR TAKING THE TIME TO READ THESE. WE ARE LOOKING FORWARD TO SEEING YOU AT YOUR APPOINTMENT.