



RHK 9   
JMT 9   
BVK 9

ACCT # \_\_\_\_\_  
DATE: \_\_\_\_\_

**Allergy, Asthma & Immunology Associates, P.C.**  
Westgate Professional Centre  
2808 So. 80<sup>th</sup> Avenue, Suite 210  
Omaha, Nebraska 68124

**PATIENT INFORMATION**  
(Please complete in full/print)

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

\_\_\_\_\_  
(LAST) (FIRST) (MI)  
ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
(STREET) (APT.) (CITY/STATE) (ZIP)  
HOME PHONE: \_\_\_\_\_ MARITAL STATUS: S M W D

PATIENT=S SSN: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_ FAMILY DOCTOR: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_  
PHONE \_\_\_\_\_ PHONE \_\_\_\_\_

**RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT):**

FATHER: \_\_\_\_\_ PHONE: \_\_\_\_\_ WORK PHONE \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_  
MOTHER: \_\_\_\_\_ PHONE: \_\_\_\_\_ WORK PHONE \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_

OTHER PARTY: \_\_\_\_\_ PHONE: \_\_\_\_\_ WORK PHONE \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

**INSURANCE INFORMATION:**

**PRIMARY INSURANCE COMPANY:**  
CARDHOLDER: \_\_\_\_\_ PHONE: \_\_\_\_\_ WORK PHONE \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_  
RELATIONSHIP: \_\_\_\_\_ CARDHOLDER=S

POLICY/I.D. #: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
GROUP/PLAN #: \_\_\_\_\_

POLICY PERCENTAGE (CIRCLE ONE): 100% 90/10% 80/20% 70/30% DEDUCTIBLE: \_\_\_\_\_

**SECONDARY INSURANCE COMPANY:**

CARDHOLDER: \_\_\_\_\_ PHONE: \_\_\_\_\_ WORK PHONE \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_  
RELATIONSHIP: \_\_\_\_\_ CARDHOLDER=S

POLICY/I.D. #: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
GROUP PLAN #: \_\_\_\_\_

I request that payment of authorized MEDICARE payments be made to Allergy, Asthma & Immunology Assoc., P.C., for any

services furnished to me by Allergy, Asthma & Immunology Assoc., P.C. I authorize holder of medical information about me to be released to MEDICARE and its agents information needed to determine these benefits or the benefits payable for related services.

MEDICARE AUTHORIZATION SIGNATURE \_\_\_\_\_

I hereby authorize Roger H. Kobayashi, M.D., James M. Tracy, D.O., and Brett V. Kettelhut, M.D. to furnish to the insurance company(s) information regarding me or my child=s health and treatment. I also hereby assign to the doctor all payments for medical services provided to me or my dependents. I understand that to the extent allowable by law, that I am responsible for any amount whether or not covered by insurance programs, Preferred Provider Organization (PPO), any Health Maintenance Organization (HMO), or any other provider of medical coverage.

PATIENT (SUBSCRIBER) SIGNATURE: \_\_\_\_\_

**PATIENTS ARE EXPECTED TO PAY AT THE TIME OF THEIR VISIT  
CO-PAY AMOUNT:  
IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, YOU MUST HAVE IT BEFORE BEING  
SEEN, THIS INCLUDES FOLLOW-UP VISITS.**