# Lisa Barisciano, M.D.
# Pediatric and Adult Asthma, Allergy & Immunology, LLC

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| □ New □ Update Information<br>Name of Primary Physician: | Referring Physician: |

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|---|---|---|---|---|
| **PATIENT NAME (Last, First, MI)** | | | **DATE OF BIRTH** | TELEPHONE (HOME) |
| E-MAIL Address | | | | TELEPHONE (Work) |
| ADDRESS (Street, Apt #) | | | | TELEPHONE (Mobile or Other) |
| CITY | STATE | ZIP | MARITAL STATUS | AGE |

| | | | |
|---|---|---|---|
| SEX (circle)<br>Male Female | SOCIAL SECURITY NUMBER | EMPLOYMENT STATUS (circle)<br>Full-Time Retired<br>Part-Time Not Employed | PATIENT STUDENT STATUS (circle)<br>If 19 Years or Older:<br>Full-Time<br>Part-Time<br>Not a Student |

***NOTE: DATE OF BIRTH REQUIRED IN ALL SECTIONS***

EMERGENCY CONTACT NAME & PHONE (& RELATIONSHIP)

**RESPONSIBLE PARTY IF PATIENT < 18 YEARS OF AGE**

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|---|---|---|---|---|
| RESPONSIBLE PARTY NAME (Last, First, MI) | | **SEX** | **DATE OF BIRTH** | PATIENT RELATIONSHIP TO RESPONSIBLE PARTY<br>Self Spouse Child Other: _____ |
| RESPONSIBLE PARTY ADDRESS (Street, Apt. #) | | | **SOCIAL SECURITY NUMBER** | TELEPHONE (Work) |
| CITY | STATE ZIP | TELEPHONE (Home) | | TELEPHONE (Emergency) |

**PRIMARY INSURANCE**

| | | | | |
|---|---|---|---|---|
| **PRIMARY POLICY HOLDER NAME** | | **SEX** | **DATE OF BIRTH** | PATIENT RELATIONSHIP TO INSURED PARTY<br>Self Spouse Child Other: _____ |
| PRIMARY INSURANCE CARRIER | TELEPHONE | GROUP NUMBER | | POLICY ID NUMBER |

**SECONDARY INSURANCE**

| | | | | |
|---|---|---|---|---|
| **SECONDARY INSURANCE POLICY HOLDER NAME** | | **SEX** | **DATE OF BIRTH** | PATIENT RELATIONSHIP TO INSURED PARTY<br>Self Spouse Child Other: _____ |
| SECONDARY INSURANCE CARRIER | TELEPHONE | GROUP NUMBER | | POLICY ID NUMBER |

Does your primary or secondary insurance require a referral to see a specialist (circle)? Primary YES / NO Secondary YES / NO

**The undersigned patient or individual acting on behalf of the patient agrees as follows:**

1. I authorize Lisa Barisciano, MD to render needed treatment to the above named patient.

2. I authorize Lisa Barisciano, MD to release medical or other information, required in the course of examination or treatment, to process patient's claims.

3. I authorize my insurance to be paid directly to the treating physician. I understand that I am responsible for charges not covered by my insurance.

4. I understand that I am responsible for all charges incurred through Lisa Barisciano, MD. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.

PATIENT / LEGAL SIGNATURE DATE