

**Texas Allergy Center**  
**Jane J. Lee, M.D., P.A.**  
Board Certified in Allergy, Asthma, and Immunology  
Board Certified in Internal Medicine

Patient: \_\_\_\_\_ SS Number: \_\_\_\_\_  
Last First MI

Sex: ( ) M ( ) F Age: \_\_\_\_ DOB: \_\_\_\_\_ Marital Status: ( ) M ( ) D ( ) S ( ) W

Home Address: \_\_\_\_\_  
City State Zip Code

Electronic Mail Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_  
City State Zip Code

**PRIMARY INSURANCE INFORMATION**

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_

Group#: \_\_\_\_\_ Benefit Verification Phone#: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_

Group#: \_\_\_\_\_ Benefit Verification Phone#: \_\_\_\_\_

In Case of Emergency, Notify: \_\_\_\_\_

Relationship: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**RELEASE OF INFORMATION:** I hereby authorize the physician and/or supplier to release any information required to process this claim and claims for any future treatment unless rescinded by me in writing.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:** I authorize payment of medical benefits to Jane J. Lee, M.D., P.A. for services performed. I also understand that any and all services (including allergy extract) that are not covered by the insurance will be my responsibility.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_