



**ALLERGY & ASTHMA FAMILY CARE
OF WESTCHESTER PLLC**

**455 CENTRAL PARK AVENUE, SUITE 207
SCARSDALE, NY 10583**

TEL: (914) 574-5720 FAX: (914)574-5723

DATE OF VISIT: _____

PATIENT'S NAME: _____ SEX: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ SOC. SEC. #: _____

PATIENT'S OCCUPATION: _____

REFERRING PHYSICIAN: _____

ADDRESS & PHONE: _____

NAME OF INSURANCE: _____

INSURANCE ID#: _____ GROUP #: _____

NAME OF INSURED: _____ DATE OF BIRTH: _____

RELATIONSHIP OF PATIENT TO INSURED:

SELF _____ SPOUSE _____ CHILD _____ OTHER _____

SECONDARY INSURANCE #: _____ GROUP#: _____

I HEREBY AUTHORIZE AND DIRECT MY INSURANCE CARRIER TO PAY DIRECTLY TO ALLERGY & ASTHMA FAMILY CARE OF WESTCHESTER, PLLC (AAFCW) ANY BENEFITS DUE ME UNDER MY INSURANCE PLAN FOR SERVICES PROVIDED BY WANG Y. MAK, M.D. OR ANY OTHER PRACTITIONER IN THIS OFFICE. I ACCEPT PERSONAL RESPONSIBILITY TO PAY THE BALANCE OF ANY CHARGES NOT PAID BY MY INSURANCE CARRIER. I FURTHER AUTHORIZE AAFCW/WANG Y. MAK, M.D. TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION TO FACILITATE THE PROCESSING OF ANY CLAIM. A COPY OF THIS AGREEMENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

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