Columbia Asthma & Allergy CLINIC

Fishers Landing ◘ Salmon Creek ◘ Longview ◘ Clackamas ◘ Gresham ◘ Fremont ◘ San Leandro ◘ Bellevue ◘ Oakland ◘ Sunnyvale ◘ Redwood City ◘ Eagle

PATIENT REGISTRATION

Today's Date:_____

Patient's Name: _____ DOB: _____ Sex:_____

Mailing Address: _____

City/State: _____ Zip code_____ SS#: _____

Email: _____ Phone#: _____

Occupation: _____Work Phone#: _____

Responsible Party:_____DOB: _____ Relationship: _____

Mailing Address: _____

City/State: _____ Zip code_____ SS#: _____

Email: _____ Phone#: _____

Occupation: _____Work Phone#: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Ins. Address: _____ Ins. Address: _____

Insured's Name: _____ Insured's Name: _____

Insured's DOB: _____ Insured's DOB: _____

ID#: _____ ID#: _____

Group#: _____ Group#: _____

Employer: _____ Employer: _____

Effective Date: _____ Effective Date: _____

Emergency Contact: _____ Relationship: _____

Primary Phone: _____ Secondary Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Columbia Asthma & Allergy Clinic or insurance company to release any information required to process my claims.

REFERRING PHYSICIAN INFORMATION FORM

Patient/Guardian Signature:_____ **Date:** _____

Sanjeev Jain, MD, PhD • Stephen Fritz, MD • Michael Noonan, MD • Jon Welch, MD
Paul Cheng, MD, PhD • Renu Gandhe, MD • Umesh Sab, MD

Were you referred to CAAC by another provider? □ Yes □ No

Referring Provider/Clinic: _____

Provider Address: _____

Physician Phone: _____ Physician Fax: _____

Type of Physician: _____

As a courtesy to other providers working on your medical team and to assist with continuity of care, CAAC is happy to send a copy of your medical records to any physician you specify. Please list them below:

Primary Care Provider/Clinic: _____

Provider Address: _____

Physician Phone: _____ Physician Fax: _____

Type of Physician: _____

Provider/Clinic: _____

Provider Address: _____

Physician Phone: _____ Physician Fax: _____

Type of Physician: _____

By signing this document, I authorize CAAC and its providers to release my medical records to the above named physicians. I may revoke this authorization at any time in writing.

Patient/Guardian Signature:_____ **Date:** _____