ENT Allergy Associates
Allergy, Asthma & Immunology
Dr. Ashley Hall, M.D.

Reminder:
No Antihistamines 7 days prior to appointment
See Allergy Skin Testing Page for examples
If unsure or you have any questions please call our office

3 Hospital Drive
Abilene, TX 79606
325-437-3600
325-437-2395 FAX

Patient Information

Appointment Date: _____ Early Arrival Time: _____Appointment Time: _____

Referring Physician: _____ Family Physician: _____

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

Social Security #: _____ E-Mail: _____

Name of Parent of Guardian (If Patient is under 18 years of Age): _____

Mailing Address: _____ APT: _____

City, State, Zip: _____ Primary Phone # (___) _____

Secondary Phone # (___) _____ Work Phone # (___) _____

FINANCIALLY RESPONSIBLE PERSON (s): (Person responsible for bill if insurance does not pay or has termed)

Name: _____DOB: _____ SSN: _____

Driver's License # _____ State: _____ we will ask to make a copy of your license

Primary Insurance: _____ 2nd Insurance: _____

Name of person who holds insurance: _____DOB: _____SSN: _____

May we leave a Message on your voice mail? ____ Yes _____ No

May we leave a message at your place of employment? ____ Yes _____ No

Please list persons with whom we can discuss your (or your child's) medical information:

Name:_____ Relationship:_____Phone:_____

Name:_____ Relationship:_____Phone:_____

Emergency Contact: _____ Relationship: _____

Primary Phone: (___) _____Secondary Phone: (___) _____

I hereby authorize the release of medical information to referring doctor and/ or any doctor to whom Dr. Ashley Hall may refer me. I authorize my family or referring doctor to release my records to Dr. Ashley Hall. I authorize the release of medical information necessary to process insurance claims and request payments of insurance benefits be made to ENT ALLERGY, ASTHMA, & IMMUNOLOGY CENTER. I hereby affirm that all information provided by me is true to the best of my knowledge, and will accept financial responsibility for my account with ENT ALLERGY, ASTHMA & IMMUNOLOGY CENTER.

Patient's Signature (or Parent/ guardian): _____ Date: _____