Amar J. Sharma, M.D., F.A.A.A.A.I.
Alena Kohler, M.S., PA-C
ALLERGY & CLINICAL IMMUNOLOGY

PATIENT INFORMATION

ALLERGY ASSOCIATES OF LEHIGH VALLEY, P.C.
940 N. NEW STREET • BETHLEHEM, PA 18018 • TELEPHONE (610) 691-1133 • FAX (610) 691-0581

Patient's Name _____

Patient's Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Social Security Number _____

Patient's Employer _____ Phone Number _____

Age_____ Birthdate _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Student

Name and Phone Number of Friend or Relative to be called in an emergency

_____

If Patient is Minor:

Father's Name _____ Birthdate _____

SS # _____ Work Number _____

Mother's Name _____ Birthdate _____

SS # _____ Work Number _____

Family Doctor _____ Phone Number _____

Doctor's Address _____

Primary Insurance

Policy Holder _____ Phone _____

Insurance Name: _____ Policy # _____

Address: _____ Plan or Group _____

_____ Subscriber's Birthdate _____

Social Security # _____

Secondary Insurance

Policy Holder _____ Phone _____

Insurance Name: _____ Policy # _____

Address: _____ Plan or Group _____

_____ Subscriber's Birthdate _____

Social Security # _____

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the above information and completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. I hereby authorize and request my insurance company to pay directly to Amar J. Sharma, M.D. the amount due me in my pending claim for basic medical, surgical, and/or major medical treatment for services rendered. I also authorize Amar J. Sharma, M.D. to release to my insurance company information about the diagnosis and treatment of my illness.

_____ _____

Signature of Patient or Parent Date