Schreiber Allergy
Emergency Contact and Insurance Information

Patient Name_____DOB _____
Email_____
Emergency Contact Name_____
Emergency Contact Number_____
Please check your preference:
May we leave a message (may include test results) on your:
_____Home Phone _____Cell Phone _____Office Phone
_____Never leave a message, only speak with me
May we leave a message (may include test results) with your:
_____Spouse _____Parent _____Significant Other
_____Other, please specify_____

Insurance Company_____
Insurance ID Number_____
Insurance Group Number_____
Name of Policy Holder _____
Policy Holder's Sex _____Male _____Female
Policy Holder's Date of Birth_____
Policy Holder's Social Security Number_____
Policy Holder's Street Address _____

This policy is through the patient's employer _____Yes _____No
Policy Holder's Employer_____

Patient's Relationship to Policy Holder _____Wife _____Husband _____Child

Do you have another health insurance company? _____Yes _____No
If yes, Name of Insurance company _____
Insurance ID Number_____
Insurance Group Number_____
Name of Policy Holder_____

Schreiber Allergy has my permission to bill the insurance companies listed above for services rendered to me or my dependent. I certify that the insurance information is accurate.

_____ _____
Date Signature of Patient or Parent/Guardian