



**GARY A. INCAUDO, M.D.**  
**NICOLE HICKS, PA-C**

145 Mission Ranch Blvd., Suite 110  
Chico, California 95926

T 530.896.2200  
F 530.896.2209

## PATIENT INFORMATION FORM

### Patient Information

Name (First, Middle, Last) \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Primary or Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance Information

#### Primary Insurance

Subscriber Name (First, Middle, Last) \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_

Subscriber ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

#### Secondary Insurance

Subscriber Name (First, Middle, Last) \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_

Subscriber ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

### Consent for Treatment & Assignment of Benefits

Allergy Associates is hereby authorized to perform all necessary and advisable medical procedures for my diagnosis and treatment. I understand that Allergy Associates will inform me of all medical procedures and treatments prior to commencement, except in case of emergency.

I assign to and approve direct payment to Allergy Associates of any insurance benefits otherwise payable for patient's treatment until this assignment is revoked by me in writing. I hereby authorize said assignee to release information necessary to secure payment. I request that payment of authorized insurance benefits be made on my behalf to Allergy Associates for any services furnished to me.

I fully understand that I am financially responsible to Allergy Associates for charges not covered by this assignment to my insurance carrier(s).

Signature \_\_\_\_\_ Date \_\_\_\_\_

Account Number \_\_\_\_\_ Verified By \_\_\_\_\_ Entry Date \_\_\_\_\_