Widdle Wheezers Asthma Consultants PLLC

TODAY'S DATE: ___________________

PATIENT NAME: ____

DATE OF BIRTH: _______________________________________ GENDER: ____________

MAILING ADDRESS: ____

____

PHONE NUMBER: ____

E-MAIL ADDRESS: ____

PARENT/GUARDIAN NAME: ____

PHARMACY NAME AND ADDRESS: ____

____

PRIMARY MEDICAL PROVIDER NAME AND PHONE: ______________________________

____

I consent to receive electronic medical communication with Widdle Wheezers Asthma Consultants in the form of email, text or telemedicine.

PARENT SIGNATURE: ____

I understand that insurance is not accepted at Widdle Wheezers Asthma Consultants and it is my responsibility for complete payment prior to services being provided.

I also understand that Widdle Wheezers Asthma Consultants will not be able to assist me in obtaining any "prior authorizations" from my medical insurance for testing or medications.

PARENT SIGNATURE: ____