PATIENT INFORMATION

Patient's Name____ Date of Birth___________________________

Sex________ Marital Status___________ Race/Ethnicity_______________ S.S. #_____________________

Address____

City_______________________________ State____________________ Zip____________________________

Home #__________________ Cell #___________________Email ____________________________________

Emergency Contact Name _______________________________Contact #_______________________________

Primary Insurance Information

Primary Insurance _______________________I.D. #_________________________Group #______________

Policy Holder's Name ______________________________Policy Holder's DOB___________________________

Secondary Insurance Information

Secondary Insurance ____________________I.D. #_________________________Group #_____________

Policy Holder's Name ______________________________Policy Holder's DOB___________________________

Pharmacy Information

Name_______________________________ Phone #___________________ Fax #______________________

Address____

Reference Information

Referring Doctor's Name_______________________ Referring Doctor's #______________________________

PCP's Name__________________________________ PCP's #_______________________________________

How did you hear about us? ____

I understand that it is my responsibility to provide the office of Allergy Associates with current and accurate billing information at the time of check-in and to notify our office immediately if there are any changes to the above information.

My signature below confirms that I have carefully reviewed the above and that all information is accurate and current unless otherwise noted.

Patient's Name and/or Authorized Representative: _____________________________________

Relationship to Patient: ____

*Patient's Signature and/or Authorized Representative: __________________________________

Date Signed: ___/___/___