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: ___/___/___