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Adult and Pediatric Allergy and Asthma Care

Patient Registration

Date: _____

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____
Gender: Male ___ Female: ___ Date of Birth: _____ Age: _____
Address: _____
City: _____ State: _____ Zip: _____
Email address: _____
Home Phone: _____ Alternate (Cell) Phone: _____
Soc. Sec. Number: _____ Marital Status: _____
Patient's Employer/School: _____ Work Phone: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Emergency Contact: _____ Phone: _____
How did you hear about us? TV ad Local News Radio Phone Book Friend Google
Other Search Engine Primary Care Provider _____

Responsible Party Same as Patient

Last Name: _____ First Name: _____ Middle Initial: _____
Gender: Male ___ Female: ___ Date of Birth: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate (Cell) Phone: _____
Soc. Sec. Number: _____ Relationship to Patient: _____
Employer: _____ Work Phone: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Is this person currently a patient in our office: Yes ___ No ___

Insured Party Same as Patient Same as Responsible Party Other:(please fill out below)

Last Name: _____ First Name: _____ Middle Initial: _____
Gender: Male ___ Female: ___ Date of Birth: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate (Cell) Phone: _____
Soc. Sec. Number: _____ Relationship to Patient: _____
Employer: _____ Work Phone: _____
Work Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance

Insurance Company: _____ Group # _____ Policy/ID # _____

Secondary Insurance

Insurance Company: _____ Group # _____ Policy/ID # _____

X _____ Date: _____
Signature of Patient or Parent if Minor

Patient Number: _____
(Office Use Only)