



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? _____

Would you like to fill out a Google Review Online through your email address _____ or sent to you by text message _____? Please check one.

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: ___/___/___