OCEAN ALLERGY
ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

PATIENT DEMOGRAPHICS FORM

Today's Date_____

Patient Name _____ **Marital Status** ___S___M___W___D

DOB_____/_____/_____ **Age** _____ **Male** ___ **Female** ___ **SSN**: _____

Address _____ **Home Phone** _____

City: _____ **Cell Phone** _____

State _____ **Zip Code** _____ **Work Phone** _____

Email: _____

Primary Care Physician: _____ **Telephone #**_____

Race _____ **Ethnicity**_____ **Preferred Language** _____

Responsible Party if Minor _____ **Relationship**_____

Address: _____ **City**_____ **State** _____ **Zip Code**_____

Employer: _____ **Tele#**_____

****Pharmacy Name** _____

****Pharmacy Address + Phone** _____

INSURANCE INFORMATION PLEASE PRESENT ALL INSURANCE CARDS

Primary Ins Co._____ **ID#:**_____ **Group#**_____

Subscriber: _____ **SSN**: _____ **DOB**: _____

Relationship to patient: _____

Secondary Ins Co. _____ **ID#** _____ **Group#** _____

Subscriber: _____ **SSN**: _____ **DOB**: _____

Relationship to Patient: _____

EMERGENCY CONTACT

Name: _____ **Telephone**: _____

I certify that the information I have given today is to the best of my ability as complete and accurate as possible. I will notify the doctor/staff of any changes or additions at subsequent visits.

RELEASE OF INFORMATION: I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS AND FINANCIAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE PAYMENT OF BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICES RENDERED.

PRINT NAME_____ **SIGNATURE**_____ **DATE** _____