

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 _____

Address: _____ City _____ State _____ Zip Code _____

Employer: _____ Occupation _____ Tele# _____

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 _____