ALLERGY, ASTHMA & CLINICAL IMMUNOLOGY
NEW PATIENT FORM

Today's Date: _____

Patient Name: _____ Marital Status ___S ___M __W ___D _____

DOB: _____ / _____ / _____ Age _____ Male Female SSN: _____

Address: _____ Phone: (_____) _____

Cell Phone: (_____) _____

City: _____ State: _____ Zip: _____

Parent Name if minor: _____

Driver's License# _____

Employer : _____OCCUPATION_____ Tel#_____

Email Address: _____@_____.___ May we email you? Yes No

Primary Care Physician: _____ Phone: _____

Referring Physician (if different): _____ Phone: _____

Pharmacy _____ Phone: _____

Other Physician _____ Phone: _____

Emergency Contact Name: _____

Relationship: _____ Phone: (_____) _____

Primary Insurance Carrier:

_____ ID#_____ Group#_____

Name of primary policy holder: _____

Policy holder's Date of Birth: _____ Policy holder's SS#: _____

Relation to Subscriber _____

Secondary Insurance Carrier

_____ ID#_____ Group#_____

Name of secondary policy holder: _____

Policy holder's Date of Birth: _____ Policy holder's SS#: _____

Relation to Subscriber _____

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.

Signature: _____ Print Name: _____ Date: _____