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** _________