Today's Date _____ ACCT. # _____Dr/Loc_____

PREFERRED FIRST NAME/NICKNAME: _____ Date of first visit _____

PATIENT INFORMATION (Please print)

PATIENT: _____ (_____)_____
Last First MI HOME PHONE

Birth Date: _____ Sex: M F PREFERRED METHOD OF COMMUNICATION (CIRCLE ONE): PHONE TEXT EMAIL

HOME ADDRESS: _____ (_____)_____
STREET CITY STATE ZIP CELL PHONE

PREFERRED EMAIL ADDRESS FOR COMMUNICATIONS: _____ CIRCLE ONE: SELF SPOUSE PARENT

PATIENT'S PHARMACY: _____ PHARMACY PHONE: (____)_____

PHARMACY ADDRESS: _____ CITY, STATE, ZIP: _____

PATIENT'S EMPLOYER: _____ BUSINESS PHONE: (_____)_____ EXT:_____

PATIENT'S PRIMARY CARE PHYSICIAN _____ PHYSICIAN PHONE (____)_____

PHYSICIAN ADDRESS _____

REFERRING PHYSICIAN (if different from Primary)_____ PHYSICAN PHONE (____)_____

PHYSICIAN ADDRESS _____

IF PATIENT IS MARRIED, NAME OF SPOUSE_____

SPOUSE CELL PHONE (____)_____ BUSINESS PHONE (____)_____EXT: _____

FAMILY INFORMATION

IF PATIENT IS A MINOR: PARENT'S NAME (1): _____PARENT'S NAME (2): _____

**MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

**If parents are unmarried or divorced:

Who can consent to medical treatment and/or receive information concerning the minor patient? _____ _____

Which parent is responsible for payment of services provided? _____

PARENT (1) ADDRESS (if diff. than above): _____ PARENT (2) ADDRESS (if diff. than above):_____

CITY, STATE, ZIP _____ CITY, STATE, ZIP _____

PARENT (1) HOME PHONE (if diff. than above): (_____)_____ PARENT (2) HOME PHONE (if diff. than above): (_____)_____

PARENT (1) EMPLOYER:_____ PARENT (2) EMPLOYER:_____

PARENT (1) WORK PHONE: (_____)_____EXT: _____ PARENT (2) WORK PHONE: (_____)_____EXT: _____

PARENT (1) CELL PHONE: (_____)_____ PARENT (2) CELL PHONE: (____)_____

PARENT (1) DATE OF BIRTH: _____ PARENT (2) DATE OF BIRTH: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Policyholder Name: _____ Policyholder Name: _____

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other

PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED, BY CASH, CHECK, OR BANKCARD

I authorize Allergy Consultants to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. These charges include any collection costs, court costs, or attorney's fees incurred due to delinquency of my bill. I certify that the information furnished by me is true and correct.

***If the above patient is a child, the policy of our office is that the parent who requests treatment for the child is responsible for all fees for the services rendered, even if that parent is not legally responsible for payment.**

Patient, *Parent, or Guardian Signature_____Date _____