

Today's Date \_\_\_\_\_ ACCT. # \_\_\_\_\_ Dr/Loc \_\_\_\_\_

PREFERRED FIRST NAME/NICKNAME: \_\_\_\_\_ Date of first visit \_\_\_\_\_

**PATIENT INFORMATION (Please print)**

PATIENT: \_\_\_\_\_ SS# \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
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) \_\_\_\_\_ PHYSICIAN PHONE (\_\_\_\_\_) \_\_\_\_\_

PHYSICIAN ADDRESS \_\_\_\_\_

IF PATIENT IS MARRIED, NAME OF SPOUSE \_\_\_\_\_

SPOUSE CELL PHONE (\_\_\_\_\_) \_\_\_\_\_ DOB: \_\_\_\_\_

Family members that are existing patients: \_\_\_\_\_

**FAMILY INFORMATION**

PARENT'S NAME (1): \_\_\_\_\_ PARENT'S NAME (2): \_\_\_\_\_

**\*\* MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED**

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 \_\_\_\_\_