PATIENT INFORMATION

INSTRUCTIONS: Please be sure to fill out all the requested information - PLEASE PRINT

PATIENT NAME:(LAST) (FIRST) (MIDDLE)			MARITAL STATUS: (CIRCLE) **S M D W SEP**		SEX: (CIRCLE ONE) **MALE FEMALE**
ADDRESS:	APT.#:		CITY:	STATE:	ZIP:
HOME TEL.#: ( )	CELL TEL.#: ( )		WORK TEL. #: ( )		EXT.
PREFERRED LANGUAGE:	DATE OF BIRTH:	AGE:	SOCIAL SECURITY #:		
EMAIL ADDRESS:	NAME OF EMPLOYER OR SCHOOL:				

RACE/ETHNICITY: ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ HISPANIC ☐ HAWAIIAN ☐ PACIFIC ISLANDER ☐ WHITE ☐ MORE THAN ONE RACE ☐ UNREPORTED/REFUSED TO REPORT

NAME OF PRIMARY CARE PHYSICIAN/PEDIATRICIAN:	PHARMACY NAME:	PHARMACY TEL.# ( )	
HOW DID YOU HEAR ABOUT ASTHMA & ALLERGY?	REFERRING PHYSICIAN (FULL NAME):	FAMILY/FRIEND/INTERNET/OTHER WRITE NAME: _____	HAVE YOU HAD ANY ALLERGY SKIN TESTING IN THE PAST 12 MONTHS? YES or NO IF YES: WHEN_____WHERE_____

IF PATIENT IS A MINOR OR STUDENT (Please fill)/ADULT EMERGENCY CONTACT

MOTHER'S NAME:	DATE OF BIRTH:		SOCIAL SECURITY #:	
ADDRESS (IF DIFFERENT):	APT.#:	CITY:	STATE:	ZIP:
HOME TEL.#: ( )	CELL TEL.#: ( )	MARITAL STATUS: (CIRCLE) **S M D W SEP**		
EMPLOYER:	OCCUPATION:	WORK TEL.#: ( )	EXT.	
FATHER'S NAME:	DATE OF BIRTH:		SOCIAL SECURITY #:	
ADDRESS (IF DIFFERENT):	APT.#:	CITY:	STATE:	ZIP:
HOME TEL.#: ( )	CELL TEL.#: ( )	MARITAL STATUS: (CIRCLE) **S M D W SEP**		
EMPLOYER:	OCCUPATION:	WORK TEL. #: ( )	EXT.	

INSURANCE CARD INFORMATION: INSURANCE AS IT APPEARS ON YOUR CARD

(PLEASE PROVIDE A COPY OF INSURANCE CARD AND PHOTO IDENTIFICATION)

PRIMARY INSURANCE COMPANY:	PRIMARY POLICY HOLDER:	DATE OF BIRTH:
PRIMARY INSURANCE ID#:	GROUP#:	
SECONDARY INSURANCE COMPANY:	PRIMARY POLICY HOLDER:	
SECONDARY INSURANCE ID#:	GROUP#:	

RELEASE AND ASSIGNMENT

I HEREBY AUTHORIZE Asthma and Allergy Associates of Florida, P.A. to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care.

I authorize the doctors, nurses or employees of Asthma and Allergy Associates of Florida, P.A. to call my home and leave a detailed message. I also understand that I am solely responsible for any outstanding balance or bill not covered or paid by my insurance company.

I also assign, transfer and set over to Asthma and Allergy Associates of Florida, P.A. all my rights, title and interest to my medical reimbursement benefits under my insurance policy with your company . I also understand that I am solely responsible for any outstanding balance or bill not covered or paid by my insurance company.

Asthma and Allergy Associates of Florida
The Allergy Group

_____ _____

PATIENT/GUARANTOR'S SIGNATURE *Adult and Pediatric Allergy and Immunology* DATE

REV 10/16