



Welcome To
ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.

NEW PATIENT INFORMATION – Please print or write clearly and fill in all the blanks.

Patient's Legal Name: _____ Soc. Sec. # _____
(First) (Middle) (Last)

Date of Birth _____ Male _____ Female _____ Home phone: () _____ Cell#: _____
Area code

Home Address: _____ City: _____ State: _____ Zip: _____

Does the patient have any known drug allergies? Yes ___ No ___ If yes, to what drugs: _____

Who referred you to our physicians? _____ Primary Care Physician: _____

Person responsible for account: _____

Complete billing address and phone for this person: _____ () _____
Address Area code Phone

If patient is an adult:

Patient's Employer: _____ Position: _____ Work Phone: () _____ Ext. _____
Area code

Marital status: Single ___ Married ___ Widowed ___ Divorced ___

Spouse's Name: _____ Soc. Sec. #: _____ Work Phone: () _____ Ext. _____
Area code

Employer: _____ Position: _____

If patient is a minor:

Child lives with: Father _____ Mother _____ Stepfather _____ Stepmother _____ Other _____

Father's name in full: _____ Soc. Sec. # _____

Father's Employer: _____ Position: _____ Work Phone: () _____ Ext. _____
Area code

Mother's name in full: _____ Soc. Sec. # _____

Mother's Employer: _____ Position: _____ Work Phone: () _____ Ext. _____
Area code

*****RE: Minor Children**

In the event that my child/children should require medical care or treatment, and my husband/wife and I should be unavailable or out of town, I give permission to the physicians of Allergy, Asthma and Immunology Associates, P.C., to care for my child/children as they deem necessary.

Signature: _____

IN CASE OF EMERGENCY, CONTACT:

Name in full: _____ Relationship: _____

Home address: _____ Home phone: () _____ Work phone: () _____ Ext. _____
Area code Area code

VISITS:

MEDICAL INSURANCE INFORMATION SHEET

******This entire sheet must be completed in full even though we have copies of your insurance cards.******

Check here if NO medical insurance: _____

If you have medical insurance:

Primary insurance company: _____

Subscriber's name: _____ Subscriber's social security #: _____

Subscriber's full address: _____

Subscriber's date of birth: _____ Subscriber's employer: _____

Subscriber's home phone: () _____ Subscriber's work phone: () _____ Ext. _____
Area code Area code

Subscriber's ID #: _____ Group #: _____

Medicaid # (if applicable): _____ Case worker: _____ Phone: () _____ Ext. _____
Area Code

Do you have a secondary medical insurance? Yes _____ No _____

If yes, please complete:

Secondary insurance company: _____

Subscriber's name: _____ Subscriber's social security #: _____

Subscriber's full address: _____

Subscriber's date of birth: _____ Subscriber's employer: _____

Subscriber's home phone: () _____ Subscriber's work phone: () _____ Ext. _____
Area code Area code

Subscriber's ID #: _____ Group #: _____

Medicaid # (if applicable): _____ Case worker: _____ Phone: () _____ Ext. _____
Area Code

RELEASE OF INFORMATION

By signing the release below, this will allow our office to help expedite the insurance claims processing for services provided by our physicians. I hereby authorize the release of any medical information necessary to process health insurance claims for services provided by physicians of Allergy, Asthma, and Immunology Associates, P.C. This authorizes our physicians to furnish to the insurance company information regarding my health and treatment.

This release will remain in effect until revoked by me in writing.

SIGNATURE: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have been informed of the Allergy, Asthma and Immunology Associates, P.C. Notice Regarding Privacy of Personal Health Information. I understand that the Notice is posted on the website, www.allergyasthmaimm.com and that a paper copy of the Notice is available to me.

Date

Patient's signature or Guardian (if patient is a minor under the age of 19 years)

ENDOCRINE:

____ Normal

Diabetes
Heat or cold intolerance

Thyroid problems

BLOOD/LYMPH NODES:

____ Normal

Enlargement of lymph glands
Anemia
Easy bruisability or bleeding
Low or high white cell count
Cancer _____

Painful lymph glands

NEUROLOGICAL:

____ Normal

Numbness or weakness
Seizures

Tingling
Headaches

PSYCHOLOGICAL:

____ Normal

Occasional Depression
On-going depression

Schizophrenia.

GENITOURINARY:

____ Normal

Urinary retention
Menstrual irregularly

Prostate problems

SENSITIVE TO:

Bee stings Latex X-ray Dye

DRUG OR ALCOHOL USE:

____ None.

____ Tobacco products presently: **(What used: i.e. cigarettes, cigars, chew)**

_____ packs/day _____ years used.

____ If no longer using: **(What used: i.e. cigarettes, cigars, chew)**

_____ packs/day _____ years used

____ Alcohol products (list what used and how often)

____ Other (list what used).

LIST MEDICATIONS YOU ARE CURRENTLY TAKING:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ Drs. Initials