ASTHMA & ALLERGY ASSOCIATES, PC AND RESEARCH CENTER

Patient Registration Form: (Please Print)

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Drivers Lic#: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____ Alternative Phone Number: (____) _____

Email Address: _____

Primary Care Physician: _____ Referring Physician: _____

Which Pharmacy do you use? _____ Location: _____ Prescription Insurance: _____

Prescription Insurance ID: _____ Mail Order Pharmacy Info: _____

How did you hear about us? _____

Please list other family members treated in our office: _____

Parent/Legal Guardian ****If under the age of 18****

Mother's Name: _____ Mother's DOB: _____

Mother's Employer _____ Employer Address _____

Father's Name: _____ Father's DOB: _____

Father's Employer _____ Employer Address _____

******Please note: All children under age 18 must be accompanied by their legal parent or legal guardian for all office visits and procedures. Exceptions will be made for children who have proof of court ordered guardianship or notarized authorization from the parent allowing another individual to accompany the child for office visits. Parents and guardians will be asked to show identification and any applicable supporting documents.**

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder DOB: _____ Policy Holder DOB: _____

Policy Holder SSN: _____ Policy Holder SSN: _____

Relation to Patient: _____ Relation to Patient: _____

I certify with my signature below that the information that I have provided is accurate and current. I consent to medical treatment for myself or minor child as the patient/legal guardian.

Signature: _____ **Date:** _____