ASTHMA & ALLERGY ASSOCIATES, PC
AND RESEARCH CENTER

Provider:_____

Patient Registration / Update

Thank you for choosing Asthma & Allergy Associates, PC as your dedicated provider for your care! To best assist your healthcare needs, please provide us with the following information.

Patient Name:_____ (Last, First, MI) Preferred Name _____

SSN:_____/____/_____ DOB ____/____/____ SEX: M_____ F_____

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

Home Address:_____

City:_____ State:_____ Zip:_____

Email Address:_____

Primary Care Physician:_____ Referring Physician:_____

Please list other family members treated in our office in the last 8 years: _____

Preferred method of contact_____(Phone, E-mail, mail)

Primary Insurance:_____	Secondary Insurance:_____
Policy Number:_____	Policy Number:_____
Group Number:_____	Group Number:_____
Policy Holder Name:_____	Policy Holder Name:_____
DOB_____ SSN_____	DOB_____ SSN_____
Relationship to Pt:_____	Relationship to Pt:_____

I would like more information regarding Research Opportunities. Yes☐ No☒

I authorize Asthma & Allergy Associates PC to leave messages on my home or alternative phone number for my care including financial obligations, clinical and prescription communication and appointment reminders. Yes☒ No☐

I authorize Asthma & Allergy Associates PC to download my prescription history from on-line pharmacies. Yes☒ No☐

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

Signature_____ Date_____