The Allergy Group
experienced • capable • friendly

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Patient Information

Patient Name:_____ SSN: _____ - _____ - _____ DOB: _____ Sex:____
First Middle Initial Last MM/DD/YYYY

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____ Email: _____

Employer: _____ Address:_____ City: _____ State: ____ Zip Code: _____

Emergency Contact: _____ Phone Number: _____ Relation to Patient: _____

Primary Care Provider: _____

Preferred Pharmacy: _____ Address/ or Cross Streets _____

Consent to pull pharmacy medication history? Yes____ No ____

Race: _____ Ethnicity: ❑ Hispanic or Latin ❑ Not Hispanic or Latin ❑ Refuse to Report

Primary Language: _____ Limited English Proficiency: Yes____ No ____

Who referred you to our clinic or how did you hear about us? _____ Veteran: Yes____ No____

Parents or Guardians (If Minor)

Name:_____ SSN: _____ - _____ - _____ DOB: _____ Sex:____
First Middle Initial Last MM/DD/YYYY

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____ Email: _____

Address: _____ City: _____ State: _____ Zip Code: _____ Relation to Patient: _____

Name:_____ SSN: _____ - _____ - _____ DOB: _____ Sex:____
First Middle Initial Last MM/DD/YYYY

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____ Relation to Patient: _____

Insurance-Primary

Insurance Name: _____ ID Number: _____ Group Number: _____

Subscriber Name:_____ SSN: _____ - _____ - _____ DOB: _____
First Middle Initial Last MM/DD/YYYY

Insurance-Secondary

Insurance Name: _____ ID Number: _____ Group Number: _____

Subscriber Name:_____ SSN: _____ - _____ - _____ DOB: _____
First Middle Initial Last MM/DD/YYYY

Financial Agreement and Authorization for treatment

I authorize treatment of the named above and agree to pay all fees and charges for such treatment. I agree to pay all for myself and members of my family shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed apon in advance. Charges shown by statements are agreed to be correct and reasonable unless protested within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/We agree to pay reasonable attorney's fees or such cost as the court determines proper. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pend ency of claims thereon, all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.

Signature:_____ (Type first and last name if electronic signature) Date: _____