Chart #: _____ **Today's Date:** _____ **Clinician:** _____

ALLERGY ASTHMA & IMMUNOLOGY ASSOCIATES, LTD

Patient Registration Form

Name: _____ Date of Birth: _____ Sex: ☐Male ☐Female

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

Marital Status (please circle) S M W D Age: _____ SS#: _____

(If patient is less than 18 years old)

Mothers Name_____ Fathers Name_____

Primary Care Physician:

First Name: _____ Last Name: _____ Phone #: _____

Referring Physician:

First Name: _____ Last Name: _____ Phone #: _____

Please ☑ box of preferred phone numbers to contact you:

☐ Home #: _____ ☐ Cell #: _____ ☐ Work #: _____

E-mail Address:

_____

Patient Employment: ☐Employed ☐Retired ☐Student ☐Unemployed ☐ Homemaker

Emergency Contact Name: _____ Relationship: _____ Phone #: _____

Insurance Information

Primary Insurance_____ Insurance Address #_____

Policy #_____ Group #_____

Name of Policy Holder: _____ Relationship to Patient: _____

Social Security #: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

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

Policy Holder Phone #: _____ Name of Employer: _____

Race/Ethnicity/Language (Required by Healthcare Reform)

Ethnicity:

☐ Caucasian	☐ Subcontinent Asian American	☐ Native American	☐ Other
☐ African American	☐ American Indian -or- Alaskan Native	☐ Asian Pacific American	☐ Refuse
☐ Asian	☐ Native Hawaiian	☐ Pacific Islander	☐ Unknown

Race: ☐ Latino/Hispanic ☐ Other ☐ Refused **Primary Language:** _____

Pharmacy Name, Address, & Phone Number:

_____

Signature (Insured or Authorized Person)