PATIENT INFORMATION

INSTRUCTIONS: Please be sure to fill out all of the requested information - PLEASE PRINT

PATIENT NAME: (LAST) (FIRST) (MIDDLE)		
MARITAL STATUS (CIRCLE): **S M D W SEP**	SEX (CIRCLE): **MALE FEMALE**	DATE OF BIRTH:
PREFERRED LANGUAGE:	ETHNICITY/RACE: ◯ AMERICAN INDIAN/ALASKAN ◯ASIAN ◯AFRICAN AMERICAN/BLACK ◯HISPANIC ◯HAWAIIAN ◯PACIFIC ISLANDER ◯WHITE ◯OTHER ◯UNREPORTED/REFUSED TO REPORT	
ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	WORK PHONE:
EMAIL ADDRESS:	SOCIAL SECURITY :	REFFERRED BY:
NAME OF PRIMARY CARE PHYSICIAN/PEDITRICIAN:	TELEPHONE:	FAX:
PHARMACY:	PHARMACY TELEPHONE NUMBER:	

IF PATIENT IS A MINOR OR STUDENT/ EMERGENCY CONTACT:

MOTHER'S NAME:	DATE OF BIRTH:	SOCIAL SECURITY:		
FATHER'S NAME:	DATE OF BIRTH:	SOCIAL SECURITY		
MOTHER'S ADDRESS:	STATE:	ZIP:	CITY:	
FATHER'S ADDRESS:	STATE:	ZIP:	CITY:	
MOTHERS OCCUPATION:	EMPLOYER:	HOME #:	CELL #:	WORK #:
FATHER'S OCCUPATION:	EMPLOYER:	HOME #:	CELL #:	WORK #:

INSURANCE CARD INFORMATION: INSURANCE AS IT APPEARS ON YOUR CARD

(PLEASE PROVIDE A COPY OF INSURANCE CARD AND PHOTO IDENTIFICATION)

PRIMARY INSURANCE COMPANY:	PRIMARY POLICY HOLDER:	
PRIMARY INSURANCE ID #:	GROUP #:	POLICY HOLDER DOB:
SECONDARY INSURANCE COMPANY:	PRIMARY POLICY HOLDER:	
SECONDARY INSURANCE ID #:	GROUP #:	POLICY HOLDER DOB:

RELEASE AND ASSIGNMENT

I HEREBY AUTHORIZE Allergy Consultants to release to your Company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care.

I AUTHORIZE the doctors, nurses or employees of Allergy Consultants to call my home and leave a detailed message. I also understand that I am solely responsible for any outstanding balance or bill not covered or paid by my insurance company.

I also assign, transfer and set over to Allergy Consultants all my rights, title and interest to my medical reimbursement benefits under my insurance policy with your company. I also understand that I am solely responsible for any outstanding balance or bill not covered or paid by my insurance company.

_____ Allergy Consultants _____

PATIENT/GUARANTOR'S SIGNATURE Robert Schramm, M.D. DATE