Patient's Last Name _____ First Name_____ Middle Initial _____

SSN _____ Date of Birth _ Age _____ Sex F ☐ M ☐

Address Apt.#_____ City _____ State___ Zip _____ County_____

Pharmacy Name and address_ __

Name & Address of Primary Care (Family) Physician or Pediatrician _____

Name & Address of Referring Physician(if different)_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Student Status: ☐ PT ☐ FT

Phone _____ Day Phone_____ Cell Phone

E-mail Address_____

Employer: _____ Employer Address: _____

What is or was your occupation? -_____ ☐ DOB

Name of Spouse/Parent/Legal Guardian_____ SSN _____

Primary Medical Insurance

Policy Holder Name_____ Policy SSN_____ DOB_____

Ins.Name_____ Policy#_____ Patient#_____

Group Name _____ Group Number _____

Ins. Co. Address _____Ins. Co. Phone Number _____ Effective Date _____

Co-pay _____ Deductible _____

Secondary Medical Insurance

Policy Holder Name_____ Policy Holder SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder# _____ Patient's Policy #_____

Group Name Ins. Co. Group Number (if applicable) _____

Address_____ Ins. Co. Phone Number

Co-Pay Amount _____ Deductible

Is this visit covered by Workers' Comp? _____

Emergency Contact: Phone#: __ _____

I will pay by: Cash ☐ Check ☐ Charge ☐

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full

I **have received Comprehensive Allergy** & **Asthma Care's notice of privacy practice,**

*Responsible Party Signature*_____ Date

Patient Name:_____ DOB:_____ Date: