

# Allergy & Clinical Immunology Medical Group

## Patient Registration

Please print clearly and fill out form completely!

### Patient Information

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ MARITAL STATUS: M S D W SEP P

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

E-MAIL \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: M F

RACE:  American Indian/Alaska Native  Asian  White/Caucasian  Black/African American  Hispanic  
 Native Hawaiian/Other Pacific Islander Other  \_\_\_\_\_

PRIMARY LANGUAGE: \_\_\_\_\_ PREFERRED PHARMACY \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

SPOUSE NAME: \_\_\_\_\_ SPOUSE EMPLOYER: \_\_\_\_\_

REFERRED BY (if physician, name and phone number): \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

IN CASE OF EMERGENCY CONTACT NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

### Insured or Responsible Party (if other than patient)

NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SEX: M F MARITAL STATUS: M S D W SEP P

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ E-MAIL \_\_\_\_\_

(For appointment reminders if patient is a child)

### Insurance Information

(Please present insurance card and I.D. to receptionist)

PRIMARY INS.: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

SECONDARY INS.: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please sign and date the financial policy on the back of this form →