Patient Information:

Patient Name:

Sex: male__ female__ Date of Birth:

Social Security Number:

Mobile Phone: Email:

Home Phone: Work Phone:

Preferred Method of Communication:

Home Phone__ Cell Phone__ Work Phone__ Email__

Patient Address:

Primary Insurance Name:

Plan Name and Type:

Insurance ID: Group ID: Effective Start Date:

Secondary Insurance Name: ☐ **Check box if no secondary insurance**

Plan Name and Type:

Insurance ID: Group ID: Effective Start Date:

Policyholder's/Guarantor Insurance Information:

Relationship of Patient to Policyholder: Self__ Spouse__ Child__ Other__

Guarantor Name:

Address:

Date of birth: Sex: male__ female__

Primary Phone:

Pharmacy you would like us to send any prescriptions:
Pharmacy Name, address, and phone:

How did you hear about us? Check one or all that apply.

____ Google ___Facebook ____Instagram
___Friend/Family ___Referral from Healthcare Provider
____Other (please specify)

If you are being referred by a physician/provider, Dr. Angela will send them a copy of the clinic note from your visit if you authorize this on the Authorization to Release Med Info sheet.

With your authorization, in order to coordinate your care, if you are self-referred or referred from a physician/provider who is not your Primary Care Provider (PCP), Dr. Angela will fax her note regarding your visit to your PCP. Please provide us with your PCP information:
PCP name, address, and phone:

Next of Kin / Emergency Contact for Patient:

Name:

Relationship to Patient: (Check one below)

Mother__ Father__ Child__ Other (Please specify relationship):________________________

Phone:

Address:

In a few words, what is the main concern you would like Dr. Angela to address?

Thank you for allowing us the opportunity to serve your allergy and asthma needs!