

PATIENT INFORMATION (Please Print)

Date _____

Patient's Name (Last, First, M.I.)	Street Address			Sex M F
City, State & Zip	Home Phone ()	Date of Birth	Age	Marital Status S M W Div Sep
Who Referred You To This Practice? / How Did You Hear of Our Practice?		Family Physician		
Social Security No.	Driver's License No.	In Case of Emergency Contact (Name / Phone No.)		
Patient's Employer	Occupation	Business Phone No.		
Employer's Street Address	City, State & Zip			
Spouse's Name	Spouse's Birthdate	Spouse's Social Security No.		
Spouse's Employer	Occupation	Business Phone No.		
Employer's Street Address	City, State & Zip			
Names of Family Members Who Are Patients Here / Relationship			Pharmacy Phone No.	

IF THE PATIENT IS A MINOR / STUDENT

Mother's Name	Street Address, City, State & Zip		Home Phone No.
Mother's Employer	Occupation	Social Security No.	Mother's Birthdate
Employer's Street Address, City, State & Zip			Business Phone No.
Father's Name	Street Address, City, State & Zip		Home Phone No.
Father's Employer	Occupation	Social Security No.	Father's Birthdate
Employer's Street Address, City, State & Zip			Business Phone No.

ADDITIONAL CONTACT INFORMATION

Cell Phone No.	Email Address (only for use by our office, will not be shared with 3 rd parties)
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INSURANCE INFORMATION

Person Responsible for Payment	Street Address, City, State & Zip	Home Phone No.
Primary Insurance Co. / Name & Address		Ins. Co. Phone No.
Name of Insured (Policy Holder)	Group / Policy No.	ID No.
Secondary Insurance Co. / Name & Address		Ins. Co. Phone No.
Name of Insured (Policy Holder)	Group / Policy No.	ID No.

Lifetime Signature Authorization

I authorize the release of any medical information necessary to process my claims. I also authorize payment of medical benefits to Allergy & Asthma Consultants of Central Florida for services rendered.

Patient's Signature _____ Date _____

Parent's Signature (If patient is under 18) _____ Date _____