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ADDITIONAL OFFICES: Oviedo • Hunters Creek • Waterford Lakes • Orange City

Patient Name:________________________________ DOB____________ Date:______________

Primary Care Physician ________________________________ **Phone**________________
Address____

We have implemented a patient portal, to which your will receive an email with a link to the portal, with log in information. We are requesting that all future prescription refills be requested through the patient portal. Please activate your log in account as soon as possible. Future scheduled appointments will be available as well. Other medical information will be available to you through our secure portal. Please be assured, your email will only be used by our office, we do not share this information with any outside sources.

Email Address____

** CMS now requires that we document the following information from our patients in our EMR. Please complete the following information. We appreciate your assistance with this:

Race:
____Asian
____Black/African American
____Hispanic/Latino
____Indian
____Mid-Eastern
____More than once race
____Pacific Islander
____Unreported/Refused to report
____White

Ethnicity:
____American Indian/Alaska Native
____Asian
____Black/African American
____Hispanic/Latino
____Indian
____Other
____Unreported/Refused to Report
____White

Preferred Language: ____English
____Spanish

**The above information is for reporting purposes only.

Please indicate which is your preferred method of contact?
____Home Phone______________________________
____Cell Phone______________________________For future updates may we text you for appointment reminders on your cell phone? Yes__________ No ________

Can we leave a message on your voice mail? Yes ______ No ______

Pharmacy Name______________________________ Phone Number____________________
Address ____

________________________________/______________________________
Signature Date

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 3rd parties)

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 ________________