INFORMATION SHEET FOR ALLERGY ASTHMA SPECIALISTS, P.A. (AAS)

Patient's Name: _____ **DOB:**_____/_____/_____ **SS#**_____/_____/_____
(Legal Name) **First** **MI** **Last** **Mo** **Day** **Year**

Marital Status: M S D W Domestic Partner **Sex:** M – F **Race:** W -B- H- A- Mix **Smoker?** Yes or No
Medication Allergies: Y or No List:_____
Ethnicity CIRCLE ONE: Caucasian African-American Hispanic Latino American Indian Non Hispanic Asian Island Pacific Hawaiian Multi
Gender Patient Identify with M F other **Sexual Orientation** Straight Bisexual Lesbian Gay Other Decline to answer
Patient Address: _____
Street **APT #** **City** **State** **Zip**
***Cell Phone*: (_____) _____ Home Phone:** (_____)_____
***EMAIL ADDRESS*:** _____

PRIMARY CARE **REFERRING DOCTOR** **PHARMACY**

Primary Physician's Name: _____ **Phone (_____) _____**
Address: _____city_____**Fax (_____) _____**

Ref Doctor: _____Phone: (_____) _____ Fax: (_____) _____

Pharmacy Name: _____ City_____ **Phone (_____) _____**
PHARMACY PLAN or (MEDICARE PART D) _____
Give your card to the Front Desk to Scan

INSURANCE INFORMATION: ******* **MUST COMPLETE** ********
Insurance Company: _____
Policy #: _____ **Group #**: _____
CLAIMS Address: _____
Insurance Phone: (_____) _____
Policy Holder's Name: _____**DOB**:_____/_____/_____
Policy Holder SS#: _____/_____/_____ relationship self-spouse child other
Home Address if different:
_____city_____st_____zip_____

Secondary Insurance: _____
Policy #: _____ Group #: _____
CLAIMS Address: _____
Insurance Phone: (_____) _____
Policy Holder's Name: _____**DOB**: _____/_____/_____
Policy Holder SS#: _____/_____/_____ self spouse child other
Home Address if different:
_____city_____st_____zip_____

PATIENT EMPLOYER ****** MUST **COMPLETE** ****** **SPOUSE OR PARTNER**

Patient's Employer: _____Work Phone (_____) _____

Spouse/Partner's Name: _____**Cell Phone**: (_____) _____

IF PATIENT IS A Child or College Student ***** **MUST COMPLETE** ********
Mother: _____DOB: _____/____/_____ SS #_____
Mother's Employer: _____ Cell Phone (_____) _____

Father: _____DOB:_____/_____/_____SS#:_____
Father's Employer: _____ Cell Phone (_____)_____

Address: _____
If different from child **Street / APT#** **City** **State** **Zip**

DATE AND INITIAL _____/_____