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/ETHNICITY: □ 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_____