Adult over 18 years Information Sheet – Allergy and Asthma Center of Corpus Christi

Have we seen anyone else in your immediate with the same insurance plan as yourself ? Y N If so, Name of patient_____
(Child/spouse/Sibbling?)

Your Name: Last_____ First:_____ Middle:_____

Address: Street_____ City:_____ ZIP:_____

Mailing address: If different than above_____

Home #: (____)_____Cell.#: (____)_____E-MAIL:_____

Best/preferred way to contact you _____Race: _____Language:_____

Social Security #:_____Birth Date:_____ Age:_____ Sex: M F

Employer:_____Occupation:_____Full or part time? Department/Floor:_____

Work Phone: (____)_____ Extension:_____ May we call you at work and leave messages?_____

Spouse: _____Birth Date: _____SSN:_____

Spouse WK Phone:(____)_____Extension:_____ Spouse Cell: _____

Who should we notify in case of an emergency? _____Phone:_____
(Other than parent or person living in your home)Relation to contact person_____

Who referred you to our office? _____
(A copy of your treatment plan will be forwarded if the above is a physician)

Who is your primary care physician?_____Phone:_____

Current Medications:_____

Allergic to any medications? _____

Reason for your visit today_____

What pharmacy do you utilize: Name: _____Location/street_____
(If there is ever a question, your prescriptions will be called to this location. Please keep this updated)

Please provide insurance cards for copying

Primary Insurance: _____Employee/Policy Holder Name_____

Secondary Insurance: _____Employee/Policy Holder Name_____

If you are a college student who is a dependant on your parents insurance

Name of parent who **Holds** your insurance policy:_____Their Employer_____

Their SSN_____ Birthdate:_____

Home Address_____ City_____State_____Zip_____

I certify that the information above is true and correct to the best of my knowledge. I have been provided opportunity to review and request a copy of Office Information and Policies, the Financial/Insurance information and Policy, and Notice of Privacy Practices. I understand it is important to keep the office updated with any changes in health status and will keep current address, employment, and phone numbers on file with the office. I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. I understand that by signing this document a copy of my records will be send the any physician listed above as a legal release of my records.

Authorized Signature: _____**Date**_____

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