Child under 18 years Information Sheet-Allergy and Asthma Center of Corpus Christi

Have we seen anyone else in your immediate family? Y N If so, Name of patient____________________
(Mother/father/brother/sister)

Child's Name: Last ____________ First: ____________ MI: ______

Physical: Street ____________ City: __________ Zip: ______

Race: __________ Language: __________ SSN: __________

Mailing address if different than above? ____________________

Email for household: ____________________

Home Phone:(____)__________ Birth Date: __________ Age: ______ Sex: M F

Father/Step Name: __________ Birthdate ________ Mother/Step Name: __________ Birthdate ________

Home Address ____________ Home Address ____________

Cell # ____________ Cell # ____________

Employer ____________ Employer ____________

Work Phone Number ____________ Work Phone Number ____________

SSN#____________: SSN#____________

Which one of the parents holds the insurance policy? ____________ (If this person is not listed above, please provide address and contact phone numbers)here -→

What is the best/preferred way to get in contact with you? ____________

If parents do not live in the same home, who does the patient reside with? ____________

Who should we notify in case of an emergency? ____________ Best Phone: ____________
(Other than parent or person living in child's home?) NAME AND RELATION ____________

Who referred you to our office? ____________

Who is the patient's pediatrician or family 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 ____________

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 also acknowledge that by signing this document I am releasing my records to my referring physician or primary care physician. The Parent/Custodian who brings the minor child in for the initial office/new patient visit will be established as the responsible party for any bills with our office.

Authorized Signature: ____________________ **Date** ____________

Relationship to child: ____________________