REDDING ALLERGY & ASTHMA SPECIALISTS

Patient Name: First_____________________ **Middle**_____________________ **Last**________________________

Birthdate: _______________________________________ **Sex:** □ Male □ Female **Race:** _____________________

Social Security Number: __________________________ **(FOR MINORS, please list parent's social security number.)**

Referral Physician: _______________________________**Location:** ____

Primary Care Physician: ___________________________**Location:** ____

Your Pharmacy Name:______________________________**Location:**_____________________**(at what intersection)**

Please be aware that this office does not use an answering service after business hours. If you need emergency assistance after the office has closed, please go to your nearest emergency room.

Mailing Address: ____
Street

____
City State Zip

Phone Numbers: (Cell) _____________________________ **(Home)** __________________________________

E-mail Address: _________________________________ **(For minors, please list a parent's e-mail address.)**

Referral Source: _Physician _Friends/Family _Internet _Insurance company _ Hospital _ZocDoc

Emergency Contact Name: ______________________________ **Phone Number:** ______________________

If patient is under 18 years old, please list names of legal guardians and contact numbers:

Legal Guardian Name: ______________________________ **Phone:** ______________________

Legal Guardian Name: ______________________________ **Phone:** ______________________

Primary Insurance: ___________________________________ **ID #**____

Primary Insurance Phone Number: ____

Primary Insurance Subscriber Name: ____________________ **DOB:** ____________ **Relationship:**______________

Secondary Insurance: __________________________________ **ID#**____

Secondary Insurance Phone Number: ____

Secondary Insurance Subscriber Name: __________________ **DOB:**_____________ **Relationship:**_______________

Please read the following statement and sign below:

The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to the physician. I also authorize Redding Allergy and Asthma Specialists to release any information required to process my claims.

Patient/Guardian Signature: ____ **Date:** _______________________