ALLERGY & ASTHMA SPECIALISTS, P.C.

PATIENT INFORMATION

Last Name: _____ First Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Language: _____ Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Other _____

Race: ❑ White/Caucasian ❑ American Indian ❑ African American ❑ Asian/Pacific Islander

Email: _____ Preferred Contact: Home Cell Work

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Care Physician: _____

INTAKE INFORMATION

Medication Allergies: _____ ❑ No Known Drug Allergies

Current Medications (include strength and dosage): _____

_____

_____

Retail Pharmacy Name: _____ Retail Pharmacy Phone: _____

Retail Pharmacy Address: _____

Mail Order Pharmacy Name: _____

Patient Height: _____ Patient Weight: _____

Tobacco Use: ❑ Current every day smoker ❑ Current some day smoker ❑ Former smoker

❑ Never smoker ❑ Unknown if smoker

Family History of Seasonal Allergies: ❑ Mother ❑ Father ❑ Sister ❑ Brother

_____ _____

Patient or Guardian Signature **Date**

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and a request that payment of benefits be made to the physician unless my account has been paid in full.

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