Allergy Asthma Food Allergy CENTERS
FREEDOM FROM YOUR ALLERGIES

South County | 9701 Landmark Parkway Dr. | Suite 207 | St. Louis, MO 63127 | Phone 314.849.8700 | Fax 314.849.8737
West County 16216 Baxter Rd. | Suite 299 | Chesterfield, MO 63017 | Phone 636.536.2600 | Fax 314.849.8700
Ste. Genevieve | 255 Boderman Ln. | Bloomsdale, MO 63267 | Phone 314.849.8700 | Fax 314.843.8737
Swansea | 510 Fullerton Rd. | Swansea, IL 62226 | Phone 618.233.8700 | Fax 314.843.8737

NEW PATIENT INFORMATION

Patient Information

Patient Name: (Last, First, MI)	Social Security #	Date of Birth _____/_____/_____	Sex ☐ M / F ☐	Marital Status Single Married Widowed Divorced Partner ☐ ☐ ☐ ☐ ☐
Street Address	City, State, Zip	Home Phone		Cell Phone
E-mail	Language English ☐ Spanish ☐ Bosnian ☐ Other ☐	Race White ☐ Black ☐ Asian ☐ Other ☐		☐ Ethnicity ☐ Hispanic / Non-Hispanic
Primary Care Physician	Phone #	Referring Physician		Phone #
Student Status: FT ☐ PT ☐ N/A ☐	School Name & Address:			

Pharmacy Name	Phone Number	Address, City, State, Zip

Financial and Insurance Information

Self or Parent #1 Name (Last, First, MI)			Parent #2 Name (Last, First, MI)		
Date of Birth _____/_____/_____	Sex ☐ M / F ☐	Relationship	Date of Birth _____/_____/_____	Sex ☐ M / F ☐	Relationship
Social Security #	E-mail		Social Security #	E-mail	
Home Phone	Cell Phone		Home Phone	Cell Phone	
Street Address			Street Address		
City, State, Zip			City, State, Zip		
Employer Name	Phone #		Employer Name	Phone #	

I hereby authorize Allergy, Asthma & Food Allergy Centers to administer treatment of the above mentioned patient. If applicable, I also, grant permission to treat my child in the event I am unable to accompany him/her to the office. I have received and read a copy of Allergy, Asthma & Food Allergy Centers revised Notice of Privacy Practice and Policy and Procedures. I authorize Allergy, Asthma & Food Allergy Centers to release any medical information acquired in the course of examination or treatment of the above named patient to his/her insurance company for payment. I authorize payment to be made directly to Allergy, Asthma & Food Allergy Centers for any services rendered and understand that I am financially responsible to Allergy, Asthma & Food Allergy Centers for charges not paid by the insurance company.

Patient / Responsible Party's Name _____

Patient / Responsible Party's Signature _____

Date _____/_____/_____