Allergy Asthma Food Allergy CENTERS
FREEDOM FROM YOUR ALLERGIES

South County | 9701 Landmark Parkway Dr. | Suite 207 | St. Louis, MO 63127
West County | 16216 Baxter Road |Suite 207 | St. Louis, MO. 63127
Illinois | 510 Fullerton Road | Swansea, IL. 62226

Phone 314.849.8700 | Fax 314.849.8737

# NEW PATIENT INFORMATION

## Patient Information

| Patient Name: (Last, First, MI) | Social Security # | Date of Birth | ☐ ex M ☐ / F | Marital Status Single Married Widowed Divorced Partner ☐ ☐ ☐ ☐ ☐ |
|---|---|---|---|---|
| Street Address City, State, Zip | | | | |
| E-mail | Language ☐ English ☐ Spanish ☐ Other | | Race ☐ ☐ ☐ ☐ | ☐ Ethnicity Hispanic / ☐ Non-Hispanic |
| Primary Care Physician | Phone # | Referring Physician | | |
| 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 | | Sex ☐ M / F ☐ | Relationship |
| Social Security No. | E-mail | | | 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_____/_____/_____