ALLERGY & ASTHMA
SPECIALISTS, P.A.

New Patient Registration

Name: ______________________________ Date of Birth: ________________________

Birth Sex: ____________________________ Current Gender: _____________________

Gender Identity: _________________________Preferred Pronoun: ___________________

Address: ____

City: ____________________________ State: __________ Zip Code: ______________

Primary Phone Number: _________________ Cell Phone Number: ___________________

Email: ______________________________________ Preferred Notification: text or email

Emergency Contact Name & Relationship (friend, brother, etc): _________________________

Emergency Contact Phone Number: ____

Employer: ____________________________ Occupation: _________________________

Primary Provider: __________________________ Phone Number: ___________________

Primary Clinic: ____________________________ Phone Number: ___________________

Referred By Provider and Clinic: _____________________ Phone Number: _____________

Reason for Visit: Allergies Food Allergies Asthma Headaches Hives Penicillin

Pediatric Patients

Mother's Name: ___________________________ Phone Number: __________________

Father's Name: ____________________________ Phone Number: __________________

Insurance

Please bring your current insurance card to your appointment!

Insurance Carrier: __________________________ Phone Number: __________________

Subscriber: _________________________ Relationship to Patient: ___________________

Group Number: ____________________ ID Number: _____________________________

Claims Address: ____

Do you need Interpreter Services: yes or no Language: ______________________________

Reminder – NO antihistamines 72 hours (3 days) prior to appointment!