ELITE ALLERGY AND ASTHMA CLINIC

New Patient Registration Form

PATIENT INFORMATION

Name (Last, First, Middle): _____ Maiden: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Phone: (_____)_____

Email Address: _____ Occupation: _____ Employer: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Spouse (Last, First, Middle): _____ Maiden: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____)_____

If the Patient is a minor (under the age of 18), please provide information for the parent or legal guardian.

Parent/Legal Guardian Name: _____ Phone: (_____)_____

INSURANCE INFORMATION

Insurance Company: _____ ID#: _____

Plan: _____ Group:_____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____ Relationship to Patient: _____

Primary Care Physician: _____ PCP Phone: (_____)_____

Preferred Pharmacy: _____ Pharmacy Phone: _____

MEDICAL HISTORY

Reason for Visit: _____

Please List Any Current or Past Medical Problems and Approximate Dates: _____

_____

_____

Please List All Current Medications, Dosage, and Duration: _____

_____

_____

Please List Any Allergies to Medications: _____

_____

MEDICAL HISTORY CONTINUED

Please List Any Major Surgeries and Approximate Dates: _____

_____

Please List Any Family History of Major Current or Past Medical Problems: _____

_____

_____

_____

Do you drink alcohol? ☐ Yes ☐ No If so, how often: _____

Do you smoke cigarettes? ☐ Yes ☐ No If so, how often: _____

Do you take prescription drugs for non-medical reasons? ☐ Yes ☐ No

Do you take illegal drugs? ☐ Yes ☐ No

AUTHORIZATION

I certify that the above information is true and accurate. I authorize the release of any medical or other information necessary to process a claim or continue medical treatment. I also authorize payment of medical benefits paid directly to **[THOMAS WILLIM, PA-C]**. I acknowledge that I am responsible for payment if my insurance company denies my claim.

_____ _____

Patient Signature Date

_____ _____

Parent or Legal Guardian Signature (If patient is a minor) Date