Allergy and Immunology Associates of Teaneck and River Edge, P. A.

PATIENT INFORMATION

Last Name: **First Name:**				**Middle Initial:**
Reason For Today's Visit:				
Social Security #:	**Home Phone#:** **Cell Phone#:**	**Date of Birth:**	**Age:**	**Sex:**
Address: **City:** **State:** **Zip Code:**				
Occupation: **Employer Name:** **Employer Address:**	**IF PATIENT IS A MINOR (FILL OUT BELOW)** **Mother's Name:** **Father's Name:** **Responsible party for payment if address is different from patient:**			
Marital Status:				
Please list any Medication Allergies:				
Please list Daily Medications:				

Primary Care Physician: _____ Address: _____Phone #:_____
Pharmacy Name:_____ Phone#: _____ Address:_____
Are there any Physical/Cultural/Religious needs that may affect your care? : No ___ Yes (Specify)_____
Primary Language Spoken: _____
How did you learn about our office? Google ___ Insurance Company ___ Other (Please Specify)_____
Have you ever been treated by an Allergist? Yes___ No ___
Previous treatment by Allergy Injections? Yes___ No ___
Previous allergy treatment by Medications? Yes___ No ___

INSURANCE INFORMATION

Name of Primary Insurance: **Patient's relationship to subscriber:**

Subscriber's name:	Subscriber's S.S. #:	Birth Date:	Group #:	Policy #:	Co-pay:

Name of Secondary Insurance: **Patient's relationship to subscriber:**

Subscriber's name:	Subscriber's S.S. #:	Birth Date:	Group #:	Policy #:	Co-pay:

IN CASE OF EMERGENCY		
Please provide the name of a local friend or relative:		
Relationship to patient:	**Home & Work Phone #:**	**Cell Phone #:**

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Allergy and Immunology Associates of Teaneck and River Edge, P. A. and or insurance company to release any information required to process my claims.

Print Patient Name: _____ _____

Patient Signature: **Date**

Print Guardian Name: (if patient is a minor) _____ _____

Guardian Signature: **Date**