Allergy & Asthma
Consultants of Mid-Michigan

Patient Information

LAST_____FIRST_____MI_____ SSN_____-_____-_____

ADDRESS_____CITY_____STATE_____ZIP_____

DATE OF BIRTH_____AGE_____SEX - M F CELL #_____ HOME#_____

E-MAIL ADDRESS FOR PT PORTAL (PARENT'S E-MAIL IF UNDER 18): _____

RACE: ☐ Asian ☐ Other Race ☐ African American ☐ American Indian OR Alaskan Native ☐ Caucasian ☐ Native Hawaiian OR Other Pacific Islander

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Native Hawaiian

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

IF UNDER 18: PARENT(S) NAME_____

FINANCIALLY RESPONSIBLE NAME & ADDRESS IF DIFFERENT FROM ABOVE:

_____

REFERRING DOCTOR (First and Last Name):_____

REFERRING DOCTOR ADDRESS_____PHONE #_____

FAMILY DOCTOR (First and Last Name): _____

FAMILY DOCTOR ADDRESS_____PHONE #_____

EMERGENCY CONTACT _____ **PHONE #** _____

RELATION TO PATIENT_____

Insurance Information	**Primary**	**Secondary**
Name of Company	_____	_____
Group And Policy #	_____	_____
Subscriber's name	_____	_____
Subscriber's DOB	_____	_____
Employer's name	_____	Employer's name:_____
Employer's address	_____	Employer's address_____

Specialty Office Copay: _____ (If you do not know your copay please call your insurance before you arrive for your appt)

I give my permission to:

YES NO Leave a message with test results on answering machine TEL#_____

YES NO Leave a message requesting a return call on my home answering machine.

YES NO Leave a message requesting a return call on my work phone.

YES NO FAX test result/information regarding my condition to FAX#_____

Release medical information regarding myself to the following persons_____

Do NOT mark under this area unless instructed to by office personnel. Thank You!

Initials: _____ Date:_____ Initials: _____ Date: _____ Initials: _____ Date: _____