WARREN ALLERGY & ASTHMA CARE,PC *31730 Hoover, Suite A* *Warren, MI 48093*

PATIENT NAME: _____
(first) (mi) (last)

Sex: M_____F_____DOB: _____/_____/_____ Age:_____ SS#_____

Address: _____
(street) (city) (state) (zip)

Telephone: Home _____ Cell _____ Work: _____

Martial Status (circle) **Single** **Married** **Widowed** **Divorced**

Employed by: _____ Employer Address _____

Primary Care Physician: _____ Phone #_____

Referred by: ☐ Patient ☐ Yellow Pages ☐ Internet ☐ Insurance ☐ Physician (Please list name/ address/ phone)
_____

INSURANCE INFORMATION

Primary Insurance:_____

Subscriber's Name: _____ DOB: _____/_____/_____ SS#_____

Member ID # _____ Group # _____ Relationship to Patient _____

Secondary Insurance: _____

Subscriber's Name _____ DOB: _____/_____/_____ SS#_____

Member ID #_____ Group #_____ Relationship to Patient_____

FOR PEDIATRIC PATIENTS

Who does the patient live with? _____Relationship to patient_____

Mother/Guardian: _____ DOB: _____/_____/_____ SS#_____

Address: (if different than above) _____
(street) (city) (state) (zip)

Telephone: Home _____ Cell_____ Work_____

Employed by: _____ Employer Address _____

Father/Guardian: _____DOB: _____/_____/_____ SS#_____

Address: (if different than above) _____
(street) (city) (state) (zip)

Telephone: Home _____ Cell_____ _____ Work_____ _____

Employed by: _____ Employer Address _____

Permission to Treat Minor when parent/guardian not present

I, _____the parent/guardian of_____,give Warren Allergy & Asthma Care, PC permission to treat my child when not accompanied by a parent or guardian. This consent shall be void upon written request.

Signature_____ Date _____