

PATIENT NAME: \_\_\_\_\_  
(first) (mi) (last)

Sex \_\_\_\_\_ M \_\_\_\_\_ F Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip)

Telephone: Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_ Emergency Phone# \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

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

**INSURANCE INFORMATION**

**Primary** Insurance: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS# \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Secondary** Insurance: \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS# \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**FOR PEDIATRIC PATIENTS**

Who does the patient live with? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Mother**/Guardian Name: \_\_\_\_\_

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

Telephone: Home ( ) \_\_\_\_\_ Wk: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Employed by: \_\_\_\_\_ Employer Address \_\_\_\_\_

**Father**/Guardian Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

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

Telephone: Home ( ) \_\_\_\_\_ Wk: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

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 \_\_\_\_\_