Patient Name: First_____ **Middle**_____ **Last**_____

Birthdate: _____ **Sex:** □ Male □ Female **Race:** _____

Social Security Number: _____ **(Optional)**

Referring Physician: _____ **Location:** _____

Primary Care Physician: _____ **Location:** _____

Your Pharmacy Name: _____**Location:** _____**(address or intersection)**

Please be aware that this office does not use an answering service after business hours. If you need emergency assistance after the office has closed, please go to your nearest emergency room.

Complete Mailing Address: _____
Street Apt/Unit/Lot (if applicable)

_____
City State Zip

Phone Numbers: (Cell) _____ **(Home)** _____

E-mail Address: _____ **(If under 18, please provide a parent's e-mail address.)**

Referral Source: (CIRCLE) Physician Friends/Family Internet Insurance company Hospital DearDoc Current Patient

Emergency Contact Name: _____**Phone Number:** _____

If patient is under 18 years old, please list names of legal guardians and contact numbers:

Legal Guardian Name: _____ **Phone:** _____

Legal Guardian Name: _____ **Phone:** _____

Primary Insurance: _____ **ID #**_____

Primary Insurance Phone Number: _____

Primary Insurance Subscriber Name: _____ **DOB:** _____ **Relationship:** _____

Secondary Insurance: _____ **ID#**_____

Secondary Insurance Phone Number: _____

Secondary Insurance Subscriber Name: _____ **DOB:** _____ **Relationship:** _____

Please read the following statement and sign below:

The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to the physician. I also authorize Redding Allergy and Asthma Specialists to release any information required to process my claims.

Patient/Guardian Signature: _____ **Date:** _____