

Patient Registration

Patient Name: First _____ Middle _____ Last _____

Birthdate: _____ Sex: Male Female Race: _____

Social Security Number: _____ (FOR MINORS, please list parent's social security number.)

Referral Physician: _____ Location: _____

Primary Care Physician: _____ Location: _____

Your Pharmacy Name: _____ Location: _____ (at what 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.

Mailing Address: _____

Street

City

State

Zip

Phone Numbers: (Cell) _____ (Home) _____

E-mail Address: _____ (For minors, please list a parent's e-mail address.)

Referral Source: Physician Friends/Family Internet Insurance company LA Fitness ZocDoc

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 Center to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____