Provo Allergy & Asthma Clinic

Patient Information

Date:_____

Patient Name:_____ Preferred Name_____ Date of Birth:_____

Address:_____ Cell Phone:_____
Street City State Zip

Preferred Phone:_____ Social Security #_____-_____-_____ ☐Male ☐Female ☐ Other _____

Preferred Language: _____ Ethnicity: ☐ Hispanic/ Latino ☐ Non-Hispanic

Race: ☐ Caucasian ☐Native American ☐Asian ☐ African American ☐Pacific Islander ☐Other_____

Patient or Responsible Party Email: _____

Referred by: _____
First & Last Name Title (M.D., P.A., N.P.) City State phone number

Have any other family members been seen in our office?_____ Who? _____

Responsible Party Information *(if different from patient)*

Name that will be on your monthly statement

Name:_____ Date of Birth:_____

Address:_____ Cell Phone:_____
Street City State Zip

Relationship to patient ☐ Spouse ☐Mother ☐Father ☐Other _____ Social Security #_____-_____-_____

Employer Name:_____ _____ Phone: _____
If self employed, please list name of business

Emergency Contact Information

All patients must provide this information

_____ Cell Phone:_____
Name of a family member not living in the same household Relationship to patient

_____Home Phone:_____
Street address City State zip

Insurance Information

Please bring your insurance card(s) with you to your appointment

Primary Insurance Company: _____

Claims Address: _____Relation to Patient_____

Name of Insured: _____Insured's Date of Birth _____

Policy / ID #_____ Group # _____

Insured SS # _____-____-_____ Employer: _____Phone: _____

Secondary Insurance Company: _____

Claims Address: _____ Insured's Date of Birth: _____

Name of Insured: _____Relation to Patient: _____

Policy / ID #_____ Group # _____

Insured SS # _____-____-_____ Employer: _____Phone: _____