IMPORTANT: Do not take antihistamines 48 hours prior to your first appointment.

Today's Date: _____

Patient's Name: _____
[First] [Middle] [Last] [Nickname]

If a minor, name of parent(s): _____

Patient's Address: _____
[Street Address] [City] [State/Zip]

Patient's Date of Birth: _____ SS#: _____

Phone Info: (____) _____ (____) _____ (____) _____
[Home] [Work] [Cell]

What is the best phone number to reach you during the day? (____) _____

E-Mail Address: _____@_____

Patient's/Parent's Employer: _____
Address: _____
Phone: _____

Emergency Contact: _____
[Name] [Relationship to Patient] [Phone #]

Patient's Primary Care Physician: _____
Address: _____
Phone: _____

Referred by: _____

Insurance Information:
Company Name: _____
Address: _____
Policy #: _____ Group #: _____
Name of Insured: _____
Insured's SS#: _____ Insured's DOB#: _____
Secondary/Supplemental Insurance: _____
_____

I hereby authorize the release of any payment and medical information necessary to process any outstanding claims for the above noted insurance company(ies).

_____ _____
[Patient or Responsible Party] [Date]

I hereby authorize medical treatment for my minor child (if applicable).

_____ _____
[Parent or Guardian] [Date]