

IDAHO ALLERGY PATIENT DEMOGRAPHIC INFORMATION

NEW PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ HOME/CELL PHONE: _____
(STREET) (CITY) (ZIP)
WORK PHONE: _____ MARITAL STATUS: _____ SPOUSE'S NAME: _____
SS #: _____ EMPLOYER: _____
SPOUSE'S EMPLOYER: _____ PHONE: _____
RELATIVE/FRIEND, OTHER THAN SPOUSE: _____
(NAME) (PHONE)
REFERRING PROVIDER: _____
(NAME) (PHONE)
PRIMARY CARE PHYSICIAN: _____
(NAME) (PHONE)
HOW DID YOU HEAR ABOUT US: _____
(PHONEBOOK, RADIO, TV, FRIEND, ETC....)

RESPONSIBLE PARTY INFORMATION

NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ HOME/CELL PHONE: _____
(STREET) (CITY) (ZIP)
WORK PHONE: _____ MARITAL STATUS: _____ SPOUSE'S NAME: _____
SS #: _____ EMPLOYER: _____
SPOUSE'S EMPLOYER: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY CARRIER
MEDICARE #: _____ MEDICAID # _____
NAME OF INSURANCE COMPANY: _____
NAME OF INSURED: _____ DOB _____ ID # _____ GROUP # _____
ADDRESS FOR MAILING CLAIMS: _____
(STREET) (CITY/STATE) (ZIP)

SECONDARY CARRIER
MEDICARE #: _____ MEDICAID # _____
NAME OF INSURANCE COMPANY: _____
NAME OF INSURED: _____ ID # _____ GROUP # _____
ADDRESS FOR MAILING CLAIMS: _____
(STREET) (CITY/STATE) (ZIP)

I ATTEST THAT I HAVE COMPLETED THE ABOVE INFORMATION ACCURATELY AND COMPLETELY TO THE BEST OF MY ABILITY. MY SIGNATURE BELOW REPRESENTS CONSENT TO BE TREATED BY IDAHO ALLERGY. THIS CONSENT ENCOMPASSES ALL PROCEDURES AND TREATMENTS AS ARE FOUND TO BE NECESSARY OR DESIREABLE, IN THE JUDGEMENT OF THE PROFESSIONAL STAFF OF IDAHO ALLERGY. IN ADDITION, I AGREE TO PAY ALL FEES AND CHARGES ASSOCIATED WITH SUCH TREATMENT. I FURTHER UNDERSTAND THAT THIS INFORMATION MAY BE UPDATED ANNUALLY AND MY CONSENT FOR TREATMENT MAY BE REVOKED IN WRITING AT ANY TIME.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE: _____ DATE: _____
(MUST BE OVER 18 FOR SIGNATURE)