ALLERGY, ASTHMA & IMMUNOLOGY CENTER, SC

325 Tamarack Lane / Shiloh, IL 62269 / (618) 624-2060 / Fax (618) 624-2226 / www.aaicenter.org / info@aaicenter.org

Date: _____

Patient Information

Name (Last, First, MI): _____

Gender (circle): Male / Female / Other

Race (circle): Asian / Native Hawaiian / Pacific Islander / African American / White / Hispanic / Other / Prefer not to answer

Marital Status (circle one): Married / Partner / Single / Widowed / Divorced / Separated

Social Security Number: _____ DOB: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Mobile: _____ Work: _____

Where may we leave a message, including private health information (check all that apply)? □ Home □ Mobile □ Work

E-mail Address: _____

Do you want "patient portal" access? □ Yes □ No

Employer Information

Employer Name: _____

Address of Employer: _____

Employer Telephone: _____ Occupation: _____

Insured Information

Name of Insured: _____

Relationship to Patient (Self, Parent, Spouse or Other): _____

Insured Parent, Spouse or Other's Date of Birth: _____

Insured Parent, Spouse or Other's Social Security Number: _____

Insurance Information

Primary Insurance:

Company: _____ **Member: _____**

Policy Number: _____ **Group Number: _____**

Secondary Insurance:

Company: _____ **Member: _____**

Policy Number: _____ **Group Number: _____**

Physician Information

Physician requesting consult (referring physician): _____ **Phone: _____**

Primary care physician: _____ **Phone: _____**

Pharmacy Information

Local Pharmacy: _____ **Address: _____**

Local Pharmacy Phone: _____ **Pharmacy Fax: _____**

Mail Order Pharmacy: _____ **Mail Order Pharmacy Fax: _____**

May we electronically access your prescription history? **□ Yes** **□ No**

Emergency Notification / Legal Guardian / Next of Kin (circle one)

Name: _____

Relationship: _____

May medical information be released to this individual? **□ Yes** **□ No**

I understand that this authorization may be withdrawn or revised by myself in writing at any time.

How did you learn about our practice? **(Please check all that apply)**

□ **Physician Referral** (Name: _____)

□ **Family Member** (Name: _____ Relationship: _____)

□ **Relative** (Name: _____ Relationship: _____)

□ **Friend** (Name: _____)

□ **Advertisement (circle) – Google / Facebook / Print (home mailer, newspaper) / AAIC website / Other: (Please list source of advertisement or name of mailer if known) _____**

Patient Signature: _____ Parent or Guardian Signature (for minor): _____

Relation to patient: _____ Date: _____