Midwest Allergy and Asthma Clinic, P.C.

Patient Information

Last Name: _____ **First Name:** _____ **Middle Initial:** ___

Birth Date: _____ **Age:** _____ **Sex:** ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Divorced

Street address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Home Phone:** _____ **Cell Phone:** _____

Insurance Information

Primary Insurance: _____ **ID Number:** _____

Subscriber Name: _____ **Subscriber Birth Date:** _____

Subscriber Address: _____

Phone: _____ **Subscriber Relationship to Patient:** _____

Secondary Insurance: _____ **ID Number:** _____

☐ **Check here if subscriber information is same as above**

Subscriber Name: _____ **Subscriber Birth Date:** _____

Subscriber Address: _____

Phone: _____ **Subscriber Relationship to Patient:** _____

Contact Authorization

Primary Email Address: _____ **Enable Patient Portal?** Y / N

Emergency Contact:

Name	Phone Number	Relationship

Please check here if Emergency Contact is **NOT** authorized to discuss medical care: __

Additional contacts authorized to speak with regarding medical care:

Name	Phone Number	Relationship

Appointment Reminders/Medical Information:

On which phone may we leave messages? **Text / Voice-Cell / Voice-Home / Do Not Call**

I have verified all the above information and have given my consent to contact me as noted in this document. Please note that it is your responsibility to contact us if any of this information changes.

Signature: _____ **Date:** _____