ALLERGY & RHEUMATOLOGY MEDICAL CLINIC, INC.
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PLEASE PRINT AND FILL IN COMPLETELY

PATIENT NAME:_____
Last *First* *M.I.*

DATE OF BIRTH: _____/_____/_____ ☐MALE ☐FEMALE
month day year

RACE: _____ ETHNICITY: _____ LANGUAGE:_____

ADDRESS: _____
Street *Apt. #* *City* *State* *Zip Code*

MAILING ADDRESS:_____
(if different from above) *Street/P.O.Box* *City* *State* *Zip Code*

E-MAIL:_____

HOME NUMBER: (_____)_____ CELL PHONE NUMBER: (_____)_____

PREFERRED METHOD OF CONTACT: HOME NUMBER OR CELL NUMBER

EMPLOYER:_____ OCCUPATION:_____
Company

_____ WORK PHONE: (_____)_____
Address *Ext.*

SPOUSE'S NAME:_____ PHONE # *(if different)*: _____

IN CASE OF EMERGENCY NOTIFY: _____ (_____)_____
Name *Phone Number*

FAMILY/PRIMARY CARE PHYSICIAN: _____

ADDRESS & PHONE #: _____

REFERRED BY *(if other than above)*: _____

PHARMACY NAME AND PHONE NUMBER:_____

MEDICARE #: _____

PRIMARY INSURANCE CO: _____	SECONDARY INSURANCE CO: _____
MEMBER NAME: _____	MEMBER NAME: _____
S.S.# or I.D.#: _____	S.S.# or I.D.#: _____
GROUP #: _____	GROUP #: _____
CO-PAY/DEDUCTIBLE: _____	CO-PAY/DEDUCTIBLE: _____

I AM AWARE AND UNDERSTAND I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED:

_____ _____
PATIENT'S SIGNATURE *DATE*