

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