NEW PATIENT INFORMATION SHEET

Please Select One: Mrs.☐ Ms.☐ Miss☐ Mr.☐ Child☐ Single☐ Married☐ Divorced☐ Widowed☐

Patient Name:

Date of Birth Age SSN Male☐ Female☐

Home Address City,St,Zip

Home Phone Cell #

Race □ White □ Asian □ Black/ African American □ Native Hawaiian or Other Pacific Islander □ American Indian-Alaskan Native

□ Other Race

Ethnicity ☐ Hispanic Latino □ Non-Hispanic or Latino Preferred Language: □ English □ Other:

EMAIL Driver's Lic. #

Preferred Means of Communication(Please Check One): □ Email □ Home Phone □ Cell Phone □ Mail □ Any

How did you hear about us? ☐Physician Name: ☐Community Event Name:

☐Flyer ☐Browsing the web ☐Friend ☐Yelp ☐Google ☐Yahoo ☐PPO Insurance Directory

FAMILY PHYSICIAN **PHYSICIAN PHONE #**

IF PATIENT IS A MINOR:

Father's Name: **Mother's Name:**

Birthday Birthday

Occupation Occupation

Employer Employer

Street Street

City,St,Zip Code City,St,Zip code

Phone # Phone #

EMERGENCY CONTACT **RELATIONSHIP** **PHONE #**

PRIMARY INSURANCE:

Ins Type: ☐ EPO ☐HMO☐PPO☐POS

Primary Insured Name D.O.B. SS#

Insured's Employer Occupation

Insurance Company Name DL #

Insurance Address Effective Date

Insurance Ph. # Relationship to Subscriber

ID # on Card Group #

SECONDARY INSURANCE:

circle: ☐ EPO ☐HMO☐PPO☐ POS

Primary Insured Name D.O.B. SS#

Insured's Employer Occupation

Insurance Company Name DL #

Insurance Address Effective Date

Insurance Ph. # Relationship to Subscriber

ID # on Card Group #

***** PLEASE READ *****

INSURANCE INFORMATION: I acknowledge that the physicians of Allergy and Asthma Assoc. may or may not be a part of the provider network for my insurance company and that it is my responsibility to verify that the providers are participating in my network. Please give your card(s) to the receptionist so we may keep a copy on file. All professional services rendered are charged to the patient/guardian. The patient is responsible for all fees regardless of insurance coverage. I hereby authorize Allergy and Asthma Assoc. to furnish all information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and that it is my responsibility to ask for an estimation of the costs of any tests being recommended/ordered prior to them being performed. My signature below indicates that I have read and agree to these said statements.

Signature: Relationship: Date:

For Opting Out Only Of Receiving Email and Text Messages Related To Appointment Reminders and Patient Care Sign Below **(Otherwise Leave Blank)**:

Signature Opting Out Email/Text Messages: Date:

Allergy & Asthma Associates of Southern California
Leading-edge, personalized care you can trust

28202 Cabot Road, Suite 105 • Laguna Niguel, CA 926977
15785 Laguna Canyon Road, Suite 100 • Irvine, CA 92618
Tel: (949) 364-2900 • Fax: (949) 365-0117

www.SoCalAllergy.com

NEW PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME:_____ TODAY'S DATE:_____
DATE OF BIRTH:_____ SEX: M F AGE:_____
EMAIL
ADDRESS:_____
PHONE:_____
REFERRED BY:_____ PCP:_____

INSTRUCTIONS FOR COMPLETING HEALTH QUESTIONNAIRE:
This form is designed to help find the cause of your problem and is an essential part of your evaluation, aiding in the proper selection of tests and treatments, and allowing us to spend more time focusing on your important problems.

**PLEASE NOTE: No antihistamines, such as Claritin, Allegra, Zyrtec, or Benadryl for at least 72 hours before your appointment, as they interfere with allergy testing. Asthma medications are allowed if needed for wheezing and coughing. If you are unsure of any medication you are presently taking, please call our office for instructions. **

CHIEF COMPLAINT: (The main reason you are here)

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_____

HISTORY OF PRESENT ILLNESS (Please provide a brief description of your current condition)

_____

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