

# 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 # \_\_\_\_\_

<b>EMERGENCY CONTACT</b>	<b>RELATIONSHIP</b>	<b>PHONE #</b>
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**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

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[www.SoCalAllergy.com](http://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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