Iowa Allergy, Asthma, & Immunology P.C.
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5901 Westown Parkway Ste.225
West Des Moines, Iowa 50266
(P) 515-410-9400
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PATIENT INFORMATION

Today's Date:_____

Last: _____ **First**: _____ **Middle**: _____ **Birthdate**: _____

Marital Status (circle) S M D W **Social Sec. No**: _____ **Sex** (Circle): Male Female

Address: _____ **Phone No**: (circle) Mobile Home **Email Address**:

City: _____ _____ _____

State/Zip: _____ **Employer:** _____

Race (circle): Caucasian, African-American, Asian, Native American, Pacific Islander
Ethnicity: Hispanic/Latino or Non-Hispanic

Parent/Guardian Information (for minors)
Mother: _____ Phone: _____
Father: _____ Phone: _____

Referring Provider: _____ **Primary Care Provider**: _____

Preferred Pharmacy Name & Address: _____

HIPAA Contacts: Authorization to Release Protected Health Information to the following individual.

Name: _____ Phone: _____ Relationship:_____

PERSONAL FINANCIALLY RESPONSIBLE INFORMATION

Name: _____ Relationship to Patient: _____

Social Sec. No: _____ Birthdate: _____ Sex (circle): Male or Female

Address: _____ Phone: _____

Employer: _____ Marital Status (circle): S M D W

PRIMARY INSURANCE INFORMATION

Primary Insurance: _____ Subscriber Name: _____ Birthdate: _____

Subscriber Home Address: _____

Relationship to Patient: _____ Social Sec. No: _____

Subscriber Employer: _____ Policy No. _____ Group No. _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance: _____ Subscriber Name: _____ Birthdate: _____

Subscriber Home Address: _____

Relationship to Patient: _____ Social Sec. No: _____

Subscriber Employer: _____ Policy No. _____ Group No. _____

IN CASE OF EMERGENCY

Name: _____ Relationship to Patient: _____ Phone No: _____

The above information is true to the best of my knowledge. I authorize Iowa Allergy to bill my insurance and contact me via text/email regarding my appointment. Please check box if you want to **opt out** of receiving text messages. ☐

Patient/Guardian Signature: _____ Date: _____