IOWA ALLERGY
ASTHMA & IMMUNOLOGY P.C.

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**: _____

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. _____

Please Turn Page Over

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: _____