

Westside Allergy Care Patient Information Form

Primary Care Doctor _____

Patient last name _____ First name _____ Middle name _____

Social security # _____ Date of birth ____/____/____ Sex _____ Marital status _____ Home phone # _____

Address (street, city, state, zip code) _____ Cell phone # _____

Employed by _____ Spouse's name _____

Employer's address _____ Employer _____

Occupation _____ Business phone # _____ Social Security # _____ Business phone # _____

Nearest friend or relative _____ Relationship to patient _____ Phone # _____

INSURANCE INFORMATION

	Insurance company name	Policyholder's name	Date of birth	Policy #
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Will this claim be covered under Worker's Compensation? Yes _____ No _____

If yes, Company name and address _____

Phone # _____ Treatment authorized by _____

RESPONSIBLE PARTY

Please complete the section below if someone other than the patient is responsible for payment for services.

Name _____ Address (street, city, state, zip code) _____

Phone # _____ Relationship to patient _____ Date of birth _____ Social Security # _____

Employer _____ Phone # _____

I have completed this form fully and completely, and certify that I am this patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment for services.

Date _____ Signature of patient, parent or responsible party _____