

Allergy & Asthma Center

of Southern Oregon, PC

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PEDIATRIC PATIENT INFORMATION

✓Name _____ Age _____ Today's Date _____
✓Date of Birth _____ Home Phone (____) _____ Social Security Number _____
✓ Mailing Address _____
✓City _____ State _____ Zip Code _____
✓Father's (or Guardian's) Name _____ ✓Mother's (or Guardian's) Name _____
✓Father's Home Phone (____) _____ ✓Mother's Home Phone (____) _____
✓Work Phone (____) _____ ✓Work Phone (____) _____
✓Cell Phone(____) _____ ✓Cell Phone(____) _____
✓E-Mail _____ ✓E-Mail _____
✓How would you prefer to be contacted Home Cell Work Email
✓ Primary Care Physician _____ ✓Referring Physician _____
✓Emergency Contact Name _____ ✓Relationship _____ ✓Emergency Phone (____) _____

Responsible Party Information

(Please complete if patient is under the age of 18 years or if insurance is through another party)

Name _____ Date of Birth _____
Social Security Number _____ Relationship to patient: Parent _____ Other _____
Mailing Address _____
City _____ State _____ Zip Code _____
✓Home Phone (____) _____ ✓Work Phone (____) _____ ✓Cell Phone(____) _____
Employer _____ Employer Address _____

INSURANCE COVERAGE

✓ Primary Insurance Name _____
Name of Policy Holder _____ Date of Birth of Policy Holder _____
Insurance Address _____
City _____ State _____ Zip Code _____
ID Number _____ Group Number _____
Secondary Insurance Name _____
Name of Policy Holder _____ Date of Birth of Policy Holder _____
Insurance Address _____
City _____ State _____ Zip Code _____
ID Number _____ Group Number _____

