ALLERGY ASSOCIATES OF THE PALM BEACHES, P.A.
PATIENT INFORMATION SHEET

PLEASE PRINT

Patient's Name:_____ Sex: _____ Date of Birth: _____/_____/_____ Age: _____

Home Address:_____ Apt #:_____ City:_____ State:____ Zip:_____

Home Phone: ( ) _____ Cell Phone: ( ) _____ SS#: _____

Seasonal/Alternate Address: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employer:_____ Occupation:_____

Work Address:_____ City:_____ State:_____ Zip:_____

Work Phone: ( ) _____ Emergency Contact (Name/ Phone #): _____

Referring Physician: _____ Phone: ( ) _____
First Name **Last Name**

Address: _____

INSURED/ RESPONSIBLE PARTY INFORMATION

If Spouse:

Name (if applicable):_____ Date of Birth:_____/ _____/_____ SS#:_____

If Patient is a Minor OR Dependent:

Mother's Name:_____ Date of Birth:_____/ _____/_____ SS#:_____

Employer:_____Work Phone:( )_____Cell Phone:( )_____

Father's Name:_____ Date of Birth:_____/ _____/_____ SS#:_____

Employer:_____Work Phone:( )_____Cell Phone:( )_____

Guardian/Other Name: _____ Date of Birth:____/ _____/_____SS#:_____

Relationship:_____

Employer:_____Work Phone:( )_____Cell Phone:( )_____

LIVING WILL/ ADVANCE DIRECTIVE

I have made provisions for a living will and/or advance directives. ☐ Yes ☐ No Signature:

_____

RESEARCH

Would you be interested in any research studies conducted by our practice? ☐ Yes ☐ No

PLEASE READ

Patients who carry medical insurance should remember that services are rendered and charged to the patient and not to the insurance company. Likewise, insurance is NOT A SUBSTITUTE FOR PAYMENT, not a method of reimbursement for payment made for services rendered. We can not render services on the assumption that all charges will be paid by the insurance company. -OR- I accept responsibility for payment of charges for services rendered to me or my minor child.

Signature: _____ Date: _____