CONE HEALTH MEDICAL GROUP **Allergy & Asthma Center of NC**
Partnering for exceptional care.

PATIENT'S NAME:_____
(FIRST) (MIDDLE) (LAST)

DATE OF BIRTH: _____ SEX: ☐ M ☐ F PATIENT SS#:_____

PATIENT'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE:_____ CELL PHONE:_____ EMAIL:_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED

PLACE OF EMPLOYMENT: _____ WORK PHONE: _____
(IF MINOR, PERSON RESPONSIBLE FOR BILL)

IF CHILD, PARENT OR GUARDIAN INFORMATION:

MOTHER'S NAME:_____ DOB:_____ SS#_____

PHONE NUMBER::_____

FATHER'S NAME:_____ DOB:_____ SS#_____

PHONE NUMBER: _____

IN CASE OF EMERGENCY CONTACT: _____ *PHONE:* _____

RELATIONSHIP TO PATIENT: _____

BILLING INFORMATION:

PERSON RESPONSIBLE FOR THE BILL: _____

BILLING ADDRESS:_____

CITY:_____ STATE: _____ ZIP: _____

PATIENT PHYSICIAN INFORMATION:

PATIENT'S PRIMARY PHYSICIAN: _____ PHONE: _____

NAME OF FACILITY / ADDRESS: _____

_____

PATIENT'S REFERRING PHYSICIAN: _____ PHONE: _____

NAME OF FACILITY / ADDRESS:_____

_____

I GIVE MY PERMISSION TO HAVE MY ALLERGY EVALUATION SENT TO MY PHYSICIANS.