# SIRVEN & ASSOCIATES ALLERGY AND ASTHMA CENTER

## PATIENT INFORMATION

Male/Hombre: _____ Female/Mujer: _____ Appointment Date/Fecha de Cita: _____

Last Name/Appedido: _____ Street Address/Direccion: _____

First Name/Nombre: _____ MI: _____City/Cuidad: _____ State/Estado: _____ Zip: _____

SS#: _____ Home Phone/Numero de casa: _____ Cell/Pager/Cellular: _____

Birth Date/ Fecha de Nacimiento: _____Age/Edad: ____ Marital Status: Single Married Widowed Divorced

E-mail address/Correo electronico: _____ Employer/Empresario: _____

Employer Address/Direccion de empleador: _____ Occupation/Ocupacion: _____

Work Phone/Telefono de Trabajo: _____ Insurance Name/Nombre de Seguro: _____

Insurance Address/Direccion de Seguro: _____

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Spouse/Conyuge: _____ Birth Date/Fecha de Nacimiento: _____ SS#: _____

Employer/Empleado: _____Occupation/Ocupacion: _____

Work Phone/Telefono de Trabajo: _____ Insurance Name/Nombre de Seguro: _____

Insurance Address/Direccion de Seguro: _____

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Primary Care Physician/Dr Primario: _____Referring Physician/Dr Referente: _____

Emergency Contact (someone outside your home): _____

Phone: _____ Relationship: _____

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**FILL OUT THIS BOX IF PATIENT IS UNDER 18 OR IF COVERED UNDER PATIENT INSURANCE**

Father's Name/Nombre del Padre: _____ Birthdate/Fecha de nacimiento: _____

Address/Direccion:_____ City/Cuidad: _____

State/Estado: _____ Zip: _____ Phone/Numero de Telefono: _____

Employer Name & Address/Empleado y Direccion: _____

Insurance Name & Address/Nombre de Seguro y Direccion: _____

Plan# or Group# / #Numero de Polica: _____ Marital Status: _____

Mother's Name/Nombre de Madre: _____ Birthdate/Fecha de nacimiento: _____

Address/Direccion:_____ City/Cuidad: _____

State/Estado: _____ Zip: _____ Phone/Numero de Telefono: _____

Employer Name & Address/Empleado y Direccion: _____

Insurance Name & Address/Nombre de Seguro y Direccion: _____

Plan# or Group# / #Numero de Polica: _____ Marital Status: _____

I hereby authorize Paragon Health DBA Advanced Allergy & Asthma Care to examine and treat me or my child and to perform such diagnostic tests as may be necessary for the duration of this illness. I hereby authorize the release of any medical information necessary to process my Medicare and/or insurance claims and for any benefits payable under my policy be paid directly to Advanced Allergy & Asthma Care. I understand that I am ultimately responsible for all payments not paid by my Medicare/Insurance. I understand that this information may include information related to the diagnosis and/or treatment of alcohol/substance abuse, pyschological/mental disorders and/or HIV serostatus. I understand that I am responsible for payment of any charges incurred.

Signature of Patient (or guardian) _____ Date: _____