Sher Allergy Specialists, LLC

Account#___________ ***PATIENT INFORMATION***

Patient Name: ___________________________________ **DOB:** ____/____/______ **SS#:** ______-______-_______ **Sex: Male** ___ **Female** ___

Address: ____ **City:** ____________________________**State:** ________**Zip:** ____________

Phone#: (_______)___________________________________ **Cell#** (________)____

☐ **Check this box if we may use this cell # for text and/or robocall appointment reminders**

Nationality: ☐**African American/Black** ☐**American Indian or Alaska Native** ☐**Asian** ☐**Native Hawaiian or Other Pacific Islander** ☐ **White**

Ethnicity: ☐**Hispanic** ☐**Non-Hispanic** ☐**Declined**

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

Email:____

Pharmacy :____ **Pharmacy Phone:** (______) ________-________________

Smoker? ☐**Current Smoker** ☐**Former Smoker** ☐**Never Smoked**

Primary Language:___________________________________ **Preferred method of contact: Email Phone Cell Phone Text**

(Please Circle One)

Employer Status: ☐**Employed** ☐**Self-Employed** ☐**Retired** ☐**Disabled** ☐**Unemployed** ☐**Student**

Occupation:____**Employer**____

Employer Address____ **Work Phone:** (_______)____________________

EMERGENCY CONTACTS

#1. Name: _______________________________________ **Relationship:** ________________________ **Phone#:** (_____) ________-____________

#2. Name: _______________________________________ **Relationship:** ________________________ **Phone#:** (_____) ________-____________

INSURANCE INFORMATION

Primary Insurance Carrier: ____________________________________ **Policy#**_________________________________**Group#**_______________

Policyholder's Name: ____ **Date of Birth**__________________________________

Policyholder's SS#:: ____ **Relationship to patient:** _____________________________________

Claims Address: ____ **City:** _____________________________**State:** ______**Zip:** _______________

Eligibility Phone# (______) _______-____________________

Secondary Insurance Carrier: ____________________________________ **Policy#**_________________________________**Group#**_______________

Policyholder's Name: ____ **Date of Birth**__________________________________

Policyholder's SS#:: ____ **Relationship to patient:** _____________________________________

Claims Address: ____ **City:** _____________________________**State:** ______**Zip:** _______________

Eligibility Phone# (______) _______-____________________

ADDITIONAL INFORMATION

Referred by: ☐**Doctor** ☐**Family** ☐**Friend** ☐**Internet Search** ☐**Insurance Book** ☐**Other**_________________________________

Please give name & Address: ____

Family Physician (PCP): ____ **Phone:** ___________________________

Do you have other family members who are patients in our office?_______________________________ **Relationship:** ___________________

Patient Signature____**Date**_______________________________________