AAHCHOO! PLLC
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| **CURRENT PATIENT INFORMATION** | | | Date: |
|---|---|---|---|
| Patient's Full Name: | | | |
| Age: | Gender: Male / Female | Marital Status: Single / Married / Divorced | |
| Patient's Date of Birth: | | Patient's Social Security #: | |
| Patient's Mailing Address: | | | Email: |
| Telephone #: Home: | | Cell: | Work: |
| Patient's Employer/ Occupation: | | | |
| Preferred Pharmacy: | | Telephone #: | |
| Emergency Contact/ Relationship: | | | Phone #: |
| Place of Employment/ Occupation: | | | Phone #: |
| Referring Physician:<br>Address:<br>Phone: | | | |
| Patient's Regular Physician:<br>Address:<br>Phone: | | | |
| If Under 18 –<br>Guardian's Full Name: | | | |
| Relationship: | Phone #: | Social Security #: | |
| Employment / Occupation: | | | |

**Any Minor patient under age 17 must have one parent/guardian present during entire visit. Due to space limitations only the patient and 1 guardian should be present for the appointment.**

**I understand that it is my responsibility to verify the benefits that are provided by my insurance company. Allergy testing is typically subject to insurance deductibles. Please be prepared to pay any unmet portion of your deductible plus co-pay at the time of your appointment.**

| Parent/Guardian Signature: | Date: |
|---|---|

If you cannot keep your appointment, please give us 24 hours advance notice.