ASTHMA & ALLERGY OF IDAHO

Welcome To Our Office!

To help us meet all your healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Date _____

Soc. Sec. # _____ Birthdate_____ Gender ◯ Female ◯ Male Cell #_____

Address_____ City_____ State _____ Zip _____

Email _____ Driver's License # _____

When confirming appointments how do you prefer to be contacted? ☐ Phone ☐ Email ☐ Text Message

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City_____ State_____ Zip_____

Spouse or Parent's Name _____ Employer _____ Work Phone_____

Primary Care Provider _____ Referring Doctor _____

Preferred Pharmacy Name _____ Pharmacy Address _____

In Case of Emergency, who would you like to be contacted?

Contact Name _____ Relationship to Patient_____

Cell Phone _____ Work Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Contact # _____ Birthdate _____

Employer _____ Work Phone_____ SSN # _____

Is this Person Currently a Patient in our Office? ◯ Yes ◯ No

Other family members who are currently a patient in our office _____ _____

For your convenience we offer the following methods of payment. Please check the option you prefer.

◯ Cash ◯ Personal Check ◯ Visa ◯ Mastercard ◯ American Express ◯ Discover ◯ Care Credit

Primary Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Secondary Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How did you hear about our office? (Check All That Apply)

☐ Brochure ☐ Google ☐ Website ☐ Yellow Pages ☐ Drive By ☐ Canyon Community Connector

☐ Dick's Pharmacy Bag ☐ Family/Friend _____ ☐ Patient _____

Authorization and Release

I certify that I have completed the above information to the best of my knowledge and is accurate. I authorize Asthma & Allergy of Idaho to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I agree to be responsible for payment of all service rendered on my behalf and of my dependents.

Signature of Patient (Parent or Minor) _____

Patient Name _____ **Date** _____