Center for Asthma, Allergy and Respiratory Disease, PLLC **EHD, Inc.**

Reason for Visit:				
Today's Date:	**Primary Care Physician:**	**Telephone:**	**Requesting Physician:**	**Telephone:**

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	☐ Dr. ☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.
Street Address:	**City:**	**State:**	**ZIP Code:**	
Home Phone No: ( )	**Cell Phone No.:** ( )	**Email:**		
Birth date:	**Age:**	**Sex:** ☐ M ☐ F	**Marital Status:** Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐	**Social Security No.:**
Employer:	**Employer phone no.:** ( )	**Ethnicity:**		
Chose CAARD because referred or heard by (Please check one box):	☐ Dr.	☐ Insurance Plan	☐ Hospital	
☐ Family	☐ Friend	☐ Close to Home/Work	☐ Yellow Pages	☐ Website	☐ Other
Other family members seen here:				
If the above named patient was a minor, may we ask the name of each parent.	Mother:	Father:		

INSURANCE INFORMATION

(Please give your insurance card to the receptionist. Statements and bills will be addressed to responsible party.)

Person Responsible for Bill:	**Birth Date:**	**Address (if different):**	**Home Phone No.:** ( )
S.S. No.:	**Driver's License No.:**		**Issuing State:**
Subscriber Name:	**Birth Date of Insurance Subscriber:**		**Sex:** ☐ M ☐ F
Patient's Relationship to Insured:	☐ Self	☐ Spouse	☐ Child	☐ Other
Name of Primary Insurance:	**Subscriber No.:**	**Group Name:**	**Group No.:**
Employer:	**Employer Address:**		**Employer Phone No.:** ( )
Name of Secondary Insurance (if applicable):	**Subscriber Name:**	**Birth Date:**	**Subscriber No.:**
Patient relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Emergency Contact:	**Relationship to Patient:**	**Cell Phone No.:** ( )	**Home Phone No.:** ( )	**Work Phone No.:** ( )

ADDITIONAL INFORMATION

Pharmacy Name and Location:	**Pharmacy Phone No.:** ( )	
Mail Order Pharmacy Name:	**Pharmacy Phone No.:** ( )	

Send Form