St. Paul Allergy & Asthma

Today's date:

PATIENT INFORMATION

Patient's Legal Last Name:	First:	MI:	Date of Birth:	Marital status (circle one) Single / Mar / Div / Widow
Home Phone:	Cell Phone:	Email address:		
Would you like to receive text message alerts? ❑ Yes ❑ No		Would you like to be enrolled in our Patient Portal? ❑ Yes ❑ No		
Street address:		City:	State:	ZIP Code:
Employer:		Employer Phone:		
Patient's Spouse/Significant Other (if applicable):		Phone Number:		

If Patient Is A Minor:

Mother's Name:	Address (if different from patient) and Phone Number:
Father's Name:	Address (if different from patient) and Phone Number:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance:	Policy Holder's Name:	Date of Birth:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		
Secondary insurance (if applicable):	Policy Holder's Name:	Date of Birth:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		

IN CASE OF EMERGENCY

Name of friend or relative (**Not living at same address**):	Relationship to patient:	Home phone:	Cell phone: