



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? <input type="checkbox"/> Yes <input type="checkbox"/> No			Would you like to be enrolled in our Patient Portal? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Secondary insurance (if applicable):		Policy Holder's Name:	Date of Birth:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

IN CASE OF EMERGENCY

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