

PATIENT INFORMATION	PLEASE PRINT WHEN FILLING OUT THIS FORM			Date: _____	
	Patient Name: _____ Age: _____				
	(Last)		(First)		(Middle)
	Date of Birth: _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced
	Address: _____				
	(Street)		(City)	(State)	(Zip)
	Best contact number: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work				
	E-Mail: _____ SSN: _____				
<small>Your e-mail address is protected and only used by Allergy & Asthma Care of Saint Louis operations</small>					
Have you or other family members received medical care by our practice?					
If yes, name: _____ Relationship: _____ When: _____					
PREFERRED PHARMACY INFORMATION					
Pharmacy: _____ Phone: _____					
Address: _____					

PHYSICIAN INFORMATION	Primary Care Physician (PCP): _____		Phone: _____	
	Address: _____		Fax: _____	
	I give my permission to send a written report(s) to the above Doctors: <input type="checkbox"/> Yes <input type="checkbox"/> No			

REFERRAL SOURCE	How did you hear about Allergy & Asthma Care of St. Louis, Dr. Kemp, Dr. Park or Dr. Berson?	
	<input type="checkbox"/> Referred by a physician; Physician's name: _____	
	<input type="checkbox"/> Referred by a family member or friend who has received care from AACOSTL; Name: _____	
	<input type="checkbox"/> Other: _____	

RESPONSIBLE PARTY	Complete this area for the patient or parent/guardian of a minor	
	Name: _____ Relationship: _____	
	Date of Birth: _____	SSN: _____ Phone: _____
	Employer: _____ Work Phone: _____	

INSURANCE INFORMATION	PRIMARY INSURANCE	SECONDARY INSURANCE
	Name of Insurance Company: _____	Name of Insurance Company: _____
	Card Holder's Name: _____	Card Holder's Name: _____
	DOB: _____ SSN: _____	DOB: _____ SSN: _____
	Member ID: _____ Group#: _____	Member ID: _____ Group#: _____
	Effective Date: _____ Co-pay: \$ _____	Effective Date: _____ Co-pay: \$ _____

BILLING PROCEDURE	BILLING PROCEDURE
	I authorize the release of any medical or other information necessary to process claims for services received from Allergy & Asthma Care of Saint Louis (hereafter referred to as "AACOSTL"). I also request payment of government benefits to myself or to the party who accepts assignment. I understand I am financially responsible for charges not covered by this authorization.
	I understand and agree if care at AACOSTL requires Primary Care Physician referral, it is my responsibility to see that the referral is current prior to receiving care at AACOSTL. If no referral is present in advance, I agree to pay for charges at the time of service.
	Signature: _____ Date: _____ Relationship to patient: _____
	CONSENT OF CARE FOR MINORS
Because my son/daughter is a minor (less than 18 years of age) and primarily supported by parent or guardian, I understand and agree that s/he may be evaluated and/or treated by AACOSTL staff if I am not present to give consent. This may include, but not necessarily be limited to physical exams, skin tests, laboratory tests, allergy injections and the prescription of medications in my absence. This agreement will be in effect until revoked by me in writing.	
Signature: _____ Date: _____ Relationship to patient: _____	