California Allergy & Asthma Medical Group, Inc.

11645 Wilshire Boulevard - Suite 1155 - Los Angeles, California 90025 - (310) 966-9022 - (310)966-9042 Fax

Patient Information Sheet

Patient Name: _____ Sex: _____ Date: _____
Date of Birth: ____ / ____ / ____ Married ___ Single ___ Divorced ___ Widowed ___
Home Address: _____ City _____ Zip _____
Patient's Social Security No: _____ - _____ - _____ Cell phone: _____
Patient's Home Phone No: _____ Work No: _____
Patient's Employer: _____ Occupation: _____
Employer Address: _____ City _____ Zip _____
Family Physician: _____ Phone No: _____
Referred By: _____ Phone No: _____

Responsible Party/Spouse/Parent: _____ SS No: _____ - ___ - _____
Spouse/Parent Phone No: _____ Date of Birth: ___ / ___ / ___
Home Address: _____ City _____ Zip _____
Spouse/Parent Employer: _____ Occupation: _____
Employer Address: _____ City _____ Zip _____
Patient E-Mail Address: _____ Pharmacy: _____

In Case of Emergency, Please Notify

Name: _____ Relation: _____
Daytime Phone No: _____ Evening Phone No: _____
Home Address: _____ City _____ Zip _____

Insurance Information

Primary Insurance Carrier Name: _____
Secondary Insurance Carrier Name: _____

This will constitute authorization for treatment by the physicians of California Allergy & Asthma Medical Group Incorporated for my child/ward or myself.

In the event of default, patient or responsible party agrees to pay all collection and attorney fees.
I hereby authorize the Insurance Carrier to pay directly to California Allergy & Asthma Medical Group Incorporated, 11645 Wilshire Boulevard, Suite 1155, Los Angeles, California 90025.

Patient or Responsible Party Signature: _____