Allergy Associates of the Palm Beaches, P.A.

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL FIELDS

Patient's Name: | **Sex: _____ Date of Birth: ____/____/____ Age: ____**

Home Address:_____ **Apt.#:**___ **City:**_____ **State:** _____ **Zip:** _____

Seasonal/Alternate Address:

_____

Home Phone: _____ **Cell Phone:** _____ | **SS#:** _____ | **Email:** _____

MARITAL STATUS
❑ **Single** ❑ **Married** ❑ **Other**_____

DRIVERS LICENSE# _____

Employer: _____

Work Phone: ( ) _____

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

Race:
❑ American/Indian
❑ Asian
❑ Black/ African American
❑ Declined
❑ Nat. Hawaiian/ Pacific Islander
❑ Other Race: _____
❑ White

Ethnicity:
❑ Declined
❑ Hispanic or Latino
❑ Not Hispanic or Latino

Primary Language: _____

Date of last flu vaccine _____ **Date of last Pneumococcal vaccine** _____ **Date of last bone density test** _____

Primary Physician: | **Referring Physician:**

Pharmacy: _____ **Phone:** _____

IN CASE OF EMERGENCY CONTACT: | **RELATIONSHIP:** | **PHONE NUMBER:**

INSURED/ RESPONSIBLE PARTY INFORMATION

RELATION TO PATIENT: ❑ **Self** ❑ **Spouse** ❑ **Parent** ❑ **Guardian**

Name: _____ **Date of Birth**: ____/____/____ **SS:**_____

Employer: _____ **Work Phone:** ( )_____ **Cell Phone:** ( )_____

DRIVERS LICENSE# _____

LIVING WILL/ ADVANCE DIRECTIVE

I have made provisions for a living will and/ or advance directives. ❑ Yes ❑ No

RESEARCH: Would you be interested in any research studies conducted by our practice? ❑ Yes ❑ No

GENERAL CONSENT

If we participate in your insurance network we will file your claim with your insurance company. Insurance is not a substitute for payment. All co-pays, co-insurance & deductibles must be paid when service is rendered. I accept responsibility for payment of charges for services rendered to me or my minor child. I give my general consent and authorize AAPB physicians, practitioners and their staff to conduct any diagnostic examinations, test and procedures to assess, diagnose and treat my illness or condition.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Name and relationship of person signing form if other than the patient

Discrimination is Against the Law-
Allergy Associates of the Palm Beaches, PA (AAPB) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability, or sex. AAB does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
Allergy Associates of The Palm Beaches cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Allergy Associates of The Palm Beaches no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.
ATTENTION: If you need language assistance services, the office will provide free of charge. Please call 561-626-2006.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 561-626-2006