02/09/2025, 16:14 New Patient Intake Form

MediCare Allergy & Wellness Center

456 Healthcare Boulevard, Suite 300 | Phone: (555) 123-4567

New Patient Intake Form

Please complete this form and bring it to your appointment or submit online 24 hours before your visit.

ast Name *	First Name *		Middle Initial
Pate of Birth *		Gender *	
MM/DD/YYYY		_ Male Fem	ale Other
lome Phone	Cell Phone *		Email Address *
treet Address *			
ity *	State *		ZIP Code *
MERGENCY CONTACT mergency Contact Name *	Relationship *		Phone Number *
NSURANCE INFORMATION			
Primary Insurance		Secondary Insurance	ce (if applicable)
Insurance Company:		Insurance Company:	
Member ID:		Member ID:	
Member ID: Group Number:		Member ID: Group Number:	
	oto ID to your appointment	Group Number:	
Group Number:		Group Number:	

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Please describe your main concern or symptoms		
low long have you been experiencing these symptoms?		
Less than 1 week 1-4 weeks 1-6 months More than 6 months		
lease check all symptoms you are currently experiencing:		
Sneezing Runny nose Stuffy nose Itchy eyes Watery eyes Skin rash/hives		
Wheezing Shortness of breath Coughing Chest tightness Sinus pressure Headaches		
ALLERGY HISTORY		
o you have any known allergies? *		
Yes No Not sure		
i vac places list all known alleggies and recetions.		
yes, please list all known allergies and reactions: Include foods, medications, environmental allergens, etc.		
The tade 100ds, medications, environmental actorgens, etc.		
/		
lave you ever had allergy testing before?		
Yes - When: No		
lave you ever used an EpiPen or had a severe allergic reaction?		
Yes No		
CURRENT MEDICATIONS		
Please list ALL current medications, vitamins, and supplements:		
Include prescription medications, over-the-counter drugs, vitamins, and		
herbal supplements. Include dosage if known.		
ro you currently taking any of those allergy medications?		
are you currently taking any of these allergy medications?		
are you currently taking any of these allergy medications? Claritin (loratadine)		
Claritin (loratadine) Zyrtec (cetirizine) Allegra (fexofenadine) Benadryl (diphenhydramine)		
Claritin (loratadine)		
Claritin (loratadine) Zyrtec (cetirizine) Allegra (fexofenadine) Benadryl (diphenhydramine)		
Claritin (loratadine)		

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ramily history of allergies or as	Family history of allergies or asthma:		
Please describe an	ny family history of allergies, asthma, or related condition		
IMPORTANT PRE-VISIT IN	ISTRUCTIONS		
CRITICAL: If allergy testin	ng is planned, you MUST stop the following medications 7 days before your appointment:		
All antihistamines (ClariCold medications contaiSleep aids like Tylenol F	· ·		
You MAY continue: Nasal s	sprays (Flonase, Nasacort), asthma inhalers, and prescription medications		
I understand the pre-visit medic	cation instructions: *		
Yes, I understand and will f	follow instructions		
	AIT		
ATIENT ACKNOWLEDGMEN			
	is accurate and complete to the best of my knowledge. I understand that providing false information may at		
pertify that the information provided i			
certify that the information provided in the street and care.	I is accurate and complete to the best of my knowledge. I understand that providing false information may at		
certify that the information provided in the street and care.	I is accurate and complete to the best of my knowledge. I understand that providing false information may at		

Please submit this form 24 hours before your appointment or arrive 15 minutes early if completing at the office.