Allergy and Asthma Consultants of Mid-Michigan, P.C.

Ridhu C. Burton, M.D. James H. Saker, M.D. Clyde R. Flory, M.D.

PATIENT INFORMATION

LAST_____FIRST_____MI_____ SSN_____

ADDRESS_____CITY_____STATE_____ZIP_____

DATE OF BIRTH_____AGE_____SEX- M F HOME #_____CELL/WK #_____

E-MAIL ADDRESS (PARENT'S E-MAIL IF UNDER 18): _____

RACE: ☐ Asian ☐ Other Race **ETHNICITY:** ☐ Hispanic or Latino **MARITAL** ☐ Single

☐ African American ☐ American Indian OR ☐ Not Hispanic or Latino **STATUS:** ☐ Married

☐ Caucasian Alaskan Native ☐ Unknown ☐ Divorced

☐ Native Hawaiian OR ☐ Native Hawaiian ☐ Widowed

Other Pacific Islander

IF UNDER 18: PARENT(S) NAME_____

FINANCIALLY RESPONSIBLE NAME & ADDRESS IF DIFFERENT FROM ABOVE:

_____

REFERRING DOCTOR (First and Last Name):_____

REFERRING DOCTOR ADDRESS_____PHONE #_____

FAMILY DOCTOR (First and Last Name): _____

FAMILY DOCTOR ADDRESS_____PHONE #_____

EMERGENCY CONTACT _____ PHONE # _____

RELATION TO PATIENT_____

Insurance Information	**Primary**	**Secondary**
Name of Company	_____	_____
Group And Policy #	_____	_____
Subscriber's name	_____	_____
Subscriber's DOB	_____	_____
Employer's name	_____	Employer's name:_____
Employer's address	_____	Employer's address_____

Specialty Office Copay: _____ (If you do not know your copay please call your insurance before you arrive for your appt)

I give my permission to:

YES NO Leave a message with test results on answering machine TEL#_____

YES NO Leave a message requesting a return call on my home answering machine.

YES NO Leave a message requesting a return call on my work phone.

YES NO FAX test result/information regarding my condition to FAX#_____

Release medical information regarding myself to the following persons_____

_____

Office use only:

Initials: _____ Date:_____ Initials: _____ Date: _____ Initials: _____ Date: _____