Adult & Pediatric Allergy & Asthma of WNY
Patient Information Record
Please print

Is your condition work related? __ yes __ no
Referred by: _____ Address: _____
Primary Care Physician: _____ Address: _____

PATIENT
Last Name: _____ **First Name:** _____ Middle Initial: __

Date of Birth: _____
Race: White ___ Black/African American ___ Native American ___ Asian ___ Other _____
Gender: ___ male ___ female Marital Status: __ single __ married __ divorced __ widowed

Address: _____ City: _____

State: _____ Zip: _____ Phone: Home # _____ Cell # _____

Work # _____ Employer: _____

INSURANCE

Primary Insurance: _____ ID# _____
Subscriber Name: _____ DOB: ___/___/____
Relationship to patient: _____ Employer: _____ Phone #:: _____

Secondary Insurance: _____ ID# _____
Subscriber Name: _____ DOB: ___/___/____
Relationship to patient: _____ Employer: _____ Phone #: _____

If patient is a minor:
Mother's Name: _____ DOB: _____
Address: _____ Apt# _____ City: _____ State ___ Zip _____
Home # _____ Cell # _____ Work # _____

Father's Name: _____ DOB: _____
Address: _____ Apt# _____ City: _____ State___ Zip _____
Home # _____ Cell # _____ Work # _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Address _____ Apt# _____ City: _____ State___ Zip_____
Home # _____ Work # _____ Cell # _____

Signature: _____ Date: _____

Please complete both sides

Patient Name: _____

LIST AND DESCRIBE DRUG ALLERGIES

Medication: _____

Reaction: _____Date:_____

Medication: _____

Reaction: _____Date:_____

LIST OF CURRENT MEDICATIONS

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Patient's Signature: _____ Date: _____
(Parent or Guardian if minor)