Allergy & Asthma of Southern Indiana, P.C.

PATIENT REGISTRATION

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

SSN: _____ DOB: _____ Gender: M or F AKA: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Phone (H): (_____)_____ Cell #: (_____)_____Work#: (____)_____

Preferred Phone: Home or Cell or Work (Please circle one)

Email: _____ Place of Employment: _____

What Pharmacy do you use: _____ City: _____

Race: (circle one): **A**sian **N**ative Hawaiian **O**ther Pacific Islander **W**hite **M**ore than one race **B**lack/African American

Ethnicity (circle one): **H**ispanic/Latino **N**on-Hispanic/Non-Latino

Preferred Language (circle one): **E**nglish **S**panish **G**erman **O**ther/Not Listed

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____

Phone (H) #: _____ Cell #: _____Work #: _____

Signature of Patient, Parent or Legal Guardian: _____

Date:_____

Form Updated: 4/28/2017