DEMERA
ALLERGY ASTHMA & ENT CENTER

Patient Information

Full Name		Today's Date	
Home Address	City	State	Zip
Telephone	D.O.B.	Age	
If patient is a minor, give parent's or guardian's name		SSN	

Responsible Party Information

Full Name		Relationship to Patient	
Mailing Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
E-Mail Address	SSN	D.O.B.	
Employer	Occupation	No. Years Employeed	
Spouse's Name	Cell Phone	Relationship to Patient	
Employer	Occupation	No. Years Employeed	
S.S.N.	D.O.B.	Work Phone	

Insurance Information

Insured's Name		Insured's S.S.N.	
Ins. Company	Grp. No.	Ins. ID No.	
Ins. Address		Ins. Phone #	
Insured's Employer		Do you have dual coverage? [Yes] [No]	
2nd Insured's Name		2nd Insured's S.S.N.	
2nd Ins. Company	Grp. No.	Ins. ID No.	
2nd Ins. Address		2nd Ins. Phone	
2nd Insured's Employer			

Emergency Information

Name of nearest relative not living with you	
Phone	Relationship

How did you hear about our practice?

Signature (Parent's Signature if minor) _____ Date _____

Update (date & initial) _____ Update (date & initial) _____ Update (date & initial) _____