Allergy Immunology Clinic of East Bay

2320 Woolsey St/ off Telegraph Ave, Berkeley, CA 94705

(925) 270- 5119

Please Print

_____/_____

New Patient Name (Last , First , Middle) IF child please indicate Parent/guardian name(last, First, Middle)

Please circle: Male / Female Child Single / Married

Age _____ Date of Birth ____/_____/_____Social Security Number_____-_____-_____

Home Address:

_____

Line 1

_____

City State Zip

(_____)_____(_____)_____

Home Phone Mobile Phone Work Phone Ext.

May we leave a message? Yes No

E-mail for internal communications only:_____

_____

Employer Name Occupation/Title Department

_____(____)_____

Primary Care Physician: Full Name Specialty Physician's Office Phone

_____(____)_____

Referring Physician: Full Name Specialty Physician's Office Phone

_____

Preferred Pharmacy: Store Name (for E-Prescribing) Address and/ & Phone Number

I choose cash option plan_(please sign if yes)_____

Or Primary Insurance _____

Insurance Company Name Phone Number (provider services)

_____

Policyholder Information(if different from above):Full Name Relationship to Patient Date of Birth Social Security Number

_____

Policyholder's Employer: Name Address City State Zip Phone Number

Secondary Insurance_____

Insurance Company Name Phone Number (provider services)

_____

Policyholder Information(if different from above):Full Name Relationship to Patient Date of Birth Social Security Number

_____

Policyholder's Employer: Name Address City State Zip Phone Number

_____(____)_____

Emergency Contact: Full Name Relationship to Patient Phone Number