**VALLEY ALLERGY AND ASTHMA CLINIC, LLC**
425 E DAHLIA AVE SUITE M-B
PALMER, AK 99645
PHONE: 907-745-4488 FAX: 907-745-4487

## Patient Demographics

| | |
|---|---|
| **Patient Name:** | I prefer to be called: |
| **Mailing Address:** | **Date of Birth:** |
| **City ,State and Zip:** | **Gender:** |
| **Physical Address** | Home Phone: |
| **City State and Zip:** | **Cell Phone** |
| **Who may we thank for referring you to us?** | Work Phone: |
| **Who is your Primary Provider?** | **May we send records to your primary care provider?** YES / NO |
| **Emergency Contact Name:** (Who should we notify in case of an emergency while at our clinic) | **Emergency Contact Phone:** |
| **Email:** | **Preferred Pharmacy:** |

*I authorize this office to send any/all information/communications regarding my treatment to this email address. I accept and agree to this*: Signature_____

**If Patient is under the age of 18 please provide the following information:**

| | |
|---|---|
| **Responsible Party (Name):** | **Date of Birth:** |
| **Address/City/State:** | **Phone:** |

**Who else can access your medical record?**

| | | |
|---|---|---|
| **Name:** | **Relationship:** | **Phone:** |
| **Name:** | **Relationship:** | **Phone:** |

**Insurance Information**

| | |
|---|---|
| **Primary Insurance:** | **Secondary Insurance** |
| **Address** | **Address:** |
| **Insurance Id:** | **Insurance Id** |
| **Group Number** | **Group Number:** |
| **Subscriber Name:** | **Subscriber Name:** |
| **Subscriber Relation:** | **Subscriber Relation:** |
| **Subscriber DOB:** | **Subscriber DOB** |

I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges regardless of insurance coverage. I have been offered a copy of Valley Allergy and Asthma Clinic, LLC's Notice of Privacy Practices.

Signature_____ Date_____