

**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**

<b>Patient Name:</b>	I prefer to be called:
<b>Mailing Address:</b>	<b>Date of Birth:</b>
<b>City ,State and Zip:</b>	<b>Gender:</b> M    F
	Home Phone:
	<b>Cell Phone</b>
<b>Who may we thank for referring you to us?</b>	Work Phone:
<b>Who is your Primary Provider?</b>	<b>May We send Records to Primary Provider? Yes / No</b>
<b>Emergency Contact Name:</b> (Who should we notify in case of an emergency while at our clinic)	<b>Emergency Contact Phone:</b>
<b>Preferred Pharmacy:</b>	

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

<b>Responsible Party(Name):</b>	<b>Date of Birth:</b>
<b>Address/City/State:</b>	<b>Phone:</b>

**Insurance Information:**

<b>Primary Insurance:</b>	<b>Secondary Insurance</b>
<b>Address</b>	<b>Address:</b>
<b>Insurance Id:</b>	<b>Insurance Id</b>
<b>Group Number</b>	<b>Group Number:</b>
<b>Subscriber Name:</b>	<b>Subscriber Name:</b>
<b>Subscriber Relation:</b>	<b>Subscriber Relation:</b>
<b>Subscriber DOB:</b>	<b>Subscriber DOB</b>

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 \_\_\_\_\_