For Office Use Only
MRN _____
DOB _____
Appt Date/Time
_____

Advanced Allergy & Asthma
Dr. Melissa Graham and Associates

500 South University • Suite 215 • Little Rock, AR 72205 • Phone 501-420-1085 • Fax 501-420-1457

NEW PATIENT PRE-REGISTRATION FORM

Today's Date: _____/_____/_____
PATIENT INFORMATION:
Name_____
Last First Middle
Patient's Social Security No._____
Mailing Address_____
City_____ State_____ Zip_____
Billing Statements will be mailed to this address.
Cell Phone (Area code)_____
Home Phone (Area code)_____
Email Address_____
Can Cell Phone be used as the primary form of communication? (circle) YES or NO If no, preferred phone:_____
Can Text Messages be sent to you on this cell phone? (circle) YES or NO
Date of Birth_____ Age____ Sex_____F _____M
Marital Status S M W D
Race ____ White/Caucasian ____ Black/African American _____Hispanic ____American Indian or Alaska Native _____Asian_____ Native Hawaiian or Other Pacific Islander
Other_____
Language _____Eng_____ Span____ Other_____

Emergency Contact (not living in same household):
Name_____
Relationship to patient_____
Phone (Area Code)_____

INSURANCE INFORMATION:
Primary Insurance Carrier, if any:
Name_____
Policyholder's Name_____ DOB_____

Secondary Insurance Carrier, if applicable:
Name_____
Policyholder's Name_____ DOB_____

PATIENT EMPLOYER:
Employer_____
Occupation_____
Business Phone (Area Code)_____
Name of Spouse_____ DOB_____
Spouse's Employer_____
Spouse's Social Security No_____

REV 06.25.20

IF PATIENT IS A MINOR:
Father's Name _____DOB_____
Father's Employer_____
Occupation_____
Father's Social Security No. _____
Business Phone (Area Code) _____
Mother's Name _____DOB_____
Mother's Employer _____
Occupation_____
Mother's Social Security No. _____
Business Phone (Area Code) _____

PHYSICIAN INFORMATION:
Name of physician who recommended that you see an allergist/asthma specialist for evaluation. _____None
Name_____
Address_____
City _____State _____ Zip_____

PATIENT'S PRIMARY CARE PHYSICIAN:
Name_____
Address_____
City_____ State_____ Zip_____

Names of other family members seen at **Advanced Allergy & Asthma** and their relationship to the patient:

Name	Relationship
_____	_____
_____	_____
_____	_____

PHARMACY:
Local Pharmacy_____
Location_____
Mail Order Pharmacy_____
Location_____
Preferred quantity of meds _____30 days _____90 days

Permission is given to review electronic prescriptions and authorizations: YES or NO

_____
Signature of Patient or Legal Guardian