<u>TO AVOID DELAYS IN TIME PLEASE COMPLETE THIS FORM IN FULL</u>
BOISE VALLEY ASTHMA & ALLERGY CLINIC
PHONE (208) 378-0080
PLEASE PRINT

PATIENT NAME: _____
LAST   FIRST   MIDDLE   SUFFIX

S.S #: _____ - _____ - _____   **DATE OF BIRTH:** _____/_____/ _____   **GENDER:** _____   **NICKNAME:** _____
                                           MM   DD   YYYY

ADDRESS: _____ **CITY, ST:** _____ **ZIP:** _____

PH. #:(_____ **)** _____-_____   **CELL #: (** _____ **)** _____ - _____   **ALT. #: (** _____ **)** _____-_____

RACE: _____ **ETHNICITY:** _____ **PREFERRED LANGUAGE:** _____

PRIMARY PHYSICIAN: _____ **REFERRING PHYSICIAN:** _____

EMPLOYER: _____ **OCCUPATION:** _____

ADDRESS: _____ **PH. #: (** _____ **)** _____ - _____

INSURANCE: _____ **POLICY #:** _____

EMERGENCY CONTACT: _____ **PH. #: (** _____ **)** _____ - _____ **RELATIONSHIP:** _____

PREFERRED METHOD OF CONTACT FOR REMINDER CALLS AND OTHER ELECTRONICALLY GENERATED MESSAGES.

(PLEASE SELECT ONLY ONE OPTION) ❏ TEXT ❏ VOICE (IF VOICE, PLEASE SELECT PREFERRED NUMBER.) ❏ HOME ❏ CELL ❏ WORK

EMAIL: _____

SPOUSE

NAME: _____ **DATE OF BIRTH:** _____/_____/_____ **S.S. #:** _____-_____-_____
                                           MM   DD   YYYY

ADDRESS: _____ **PH. #: (** _____ **)** _____ - _____

EMPLOYER: _____ **PH. #: (** _____ **)** _____ - _____

INSURANCE: _____ **POLICY #:** _____

PARENTS OR GUARDIANS (if minor)

FATHER: _____ **DATE OF BIRTH:** _____/_____/_____ **S.S. #:** _____-_____-_____
                                           MM   DD   YYYY

ADDRESS: _____ **PH. #: (** _____ **)** _____ - _____

EMPLOYER: _____ **PH. #: (** _____ **)** _____ - _____

INSURANCE: _____ **POLICY #:** _____

MOTHER: _____ **DATE OF BIRTH:** _____/_____/_____ **S.S. #:** _____-_____-_____
                                           MM   DD   YYYY

ADDRESS: _____ **PH. #: (** _____ **)** _____ - _____

EMPLOYER: _____ **PH. #: (** _____ **)** _____ - _____

INSURANCE: _____ **POLICY #:** _____

RESPONSIBLE PARTY
PLEASE COMPLETE THIS SECTION IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR THE BILL

NAME: _____ **DATE OF BIRTH:** _____/_____/_____ **S.S. #:** _____-_____-_____
                                        MM   DD   YYYY

ADDRESS: _____ **PH. #: (** _____ **)** _____ - _____

RELATIONSHIP TO PATIENT: _____ **PAYMENT METHOD:** _____

SIGNATURE OF RESPONSIBLE PARTY: _____

.