VALLEY ALLERGY AND ASTHMA CLINIC, LLC
12113 E Maple Springs Way
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:** M F
Cell Phone Home Phone:	Work Phone:
Who may we thank for referring you to us?	
Who is your Primary Provider?	**May We send Records to Primary Provider?** Yes / No
Emergency Contact Name: (Who should we notify in case of an emergency while at our clinic)	**Emergency Contact Phone:**
Preferred Pharmacy:	

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

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

I **DO** / **DO NOT** (circle one) authorize this office to utilize *Surecripts Medication History* (a secure and HIPAA compliant electronic service that provides patient medication history to medical users) to obtain my medication information. This service allows us to reconcile your medications and helps ensure that we provide you with the best possible care.

Signature_____ Date_____

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_____