THE KAGEN ALLERGY CLINIC, S.C.

PATIENT INFORMATION

Name_____Birth_____/____/_____ Sex F M

Address _____
Street City State Zip

Phone (home) _____ Cell # _____

Marital Status: S M D W Social Security Number _____

Employer_ _____ Employer Phone _____

Physician _____

Address_____ Phone _____

MEDICAL INFORMATION

What allergy problems do you have? _____

_____

How long have you had this these problems? _____

_____

Have you ever had allergy tests? **Yes** **No** When? _____

Have you ever had allergy shots? **Yes** **No** Dates _____

Where did you receive these injections? _____

Do you have Pets? **Yes** **No** What kind? _____

Do you smoke? **Yes** **No**

Other medical problems: _____

INDIVIDUAL RESPONSIBLE FOR PAYMENT

Name:_____ Relationship _____

Address: _____
Street City State Zip

Phone (home)_____ Cell # _____

INSURANCE

Insurance Company _____

Insurance Company Address _____

Subscriber Number_____Group Number _____

Individual Carrying Insurance_____Relationship to Patient _____

Address (if different from above) _____
(Street City State Zip)

Phone_____ Social Security Number _____

Date Birth _____/ ____/____ Sex F M

Employer_____Phone _____

I hereby authorize my insurance benefits to be paid directly to The Kagen Allergy Clinic S.C. realizing I am personally responsible for payment of any and all non-covered services, and thereby I authorize the release of pertinent medical information to insurance carriers. In the absence of insurance coverage, I understand I am responsible for all charges incurred, including any and all electronic forms of communications via telephone, email, live video chats and text messages, for which charges may occur. I further understand allergy tests may result in itching, swelling, difficulty breathing or life threatening systemic reactions, which may require adrenaline, other emergency treatments or hospitalizations to prevent death, and I hereby accept any and all risks associated with said tests.

_____ _____
Patient or Guardian Signature Date

_____ _____
Staff Signature Date