ALLERGY & ASTHMA SPECIALISTS MEDICAL GROUP
PATIENT INFORMATION

☐ **HUNTINGTON BEACH** ☐ **IRVINE**

(Please Print)

Patient's Name	Date Of Birth	M	S	Age	Sex *(Circle)* ***M F***

Address	City/State	Zip	Cell Phone#
Patient's Employer	Occupation	SS #	CA Driver's License #
Employer's Address	City/State	Zip	Work Phone#
Email Address			Home Phone#
Emergency Contact	Relationship	Phone#	Alternate Phone#

If Patient Is a Minor or Student

Mother's Name	Address	City	Cell Phone#
Mother's Employer			Work Phone#
Mother's SS #	Mother's Driver's License #	Father's SS #	Father's Driver's License #
Father's Name	Address	City	Cell Phone#
Father's Employer			Work Phone#

Insurance Information
Primary Insurance

Name of Insured *(Main Policy Holder)*	Address	City	Phone #
Insurance Company	Policy or Group #	Insured	Insured ID #
Insurance Company Address	City/State	Zip	Medical Group

Secondary Insurance (If Applicable)

Name of Insured *(Main Policy Holder)*	Address	City	Phone #
Insurance Company	Policy or Group #	Insured	Insured ID #
Insurance Company Address	City/State	Zip	Medical Group

Preferred Pharmacy

I hereby authorize **Steven F. Weinstein, M.D.,** or employees of the Allergy and Asthma Specialists Medical Group to render any treatment deemed necessary in diagnosing or treating my condition or that of my dependent.

Authorization: I authorize Dr. Weinstein to furnish information to insurance carriers concerning this service and irrevocably assign to the doctor payments for these services rendered. *I understand that I am ultimately responsible for all charges whether or not covered by insurance.*

Referred By	Responsible Party Signature	Date