The Asthma & Allergy Center

3503 Samson Way #108 • Bellevue, NE 68123-4303 PHONE (402) 592-2055 FAX (402) 592-2419 www.asthmaandallergycenter.com

Patient Information

Date_____ **(Please Print)**

Patient Name _____ Social Security # _____
Last First Initial

Address _____ Home Phone ( ) _____

City/State/Zip _____ Work Phone ( ) _____Ext.___

Preferred phone to leave a brief message? ☐Home ☐Work ☐Cell Cell Phone ( ) _____

Date of Birth _____Age _____ ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated

☐Male ☐Female

Do you have an Advance Directive? ☐Yes ☐No If so, is it on file at your Primary Care Physician's Office? ☐Yes ☐No
An Advance Directive includes Living Will, Resuscitate, Do Not Resuscitate, Organ Donor, or Health Care Power of Attorney.

E-Mail Address (used for the Patient Portal) _____

Race: ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Black/African American ☐ White ☐ Hispanic ☐ Other: _____

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Decline

Language, if other than English _____

Does the patient need an interpreter? ☐Yes ☐No If yes, what type? _____
Spanish, sign language, etc.

* *

Referring M.D. _____ Primary Care Physician (PCP) _____

Referring M.D. Address _____ PCP Address _____

City/State/Zip _____ City/State/Zip _____

Ref. M.D. Phone _____ PCP Phone _____

* *

Employer_____Occupation _____

Employer Address_____How long?_____

City/State/Zip _____Phone Number _____

☐Full Time ☐Part Time ☐Retired ☐Not Employed

* * * * * * * * * * * * Emergency Contact * * * * * * * * * * * *

Name_____Relationship _____

Address _____Phone _____

City/State/Zip _____

* * * * * * * * * * * * Pharmacy Information * * * * * * * * * * * *

Main Pharmacy _____ Location/Phone Number _____

Mail Order Pharmacy (if applicable) _____ Location/Phone Number _____

Secondary Pharmacy (if applicable) _____ Location/Phone Number _____