# ALLERGY & ASTHMA MEDICAL GROUP AND RESEARCH CENTER, A P.C.
# (AAMGRC)

## PATIENT INFORMATION

**LAST NAME**: ______________________________________________

**FIRST NAME**: ______________________________________________

**MIDDLE NAME**: ______________________________________________

**DATE OF BIRTH**: ______________________________________________

**SEX**: ☐ MALE ☐ FEMALE

**eMAIL**
Primary: ______________________________________________

Other: ______________________________________________

**PHONE**
CELL: (__________)______________________________________

WORK: (__________)______________________________________

OTHER: (__________)______________________________ *Home / Cell*

**MAILING ADDRESS**

______________________________________________________

______________________________________________________

OTHER FAMILY MEMBERS WHO ARE PATIENTS?

______________________________________________________

## SPOUSE/PARTNER'S CONTACT INFORMATION

**MARRIED**: ☐ YES ☐ NO

SPOUSE/PARTNER'S NAME:______________________________________

**eMAIL**
Primary: ______________________________________________

Other: ______________________________________________

**PHONE**
CELL: (__________)______________________________________

WORK: (__________)______________________________________

OTHER: (__________)______________________________ *Home / Cell*

**MAILING ADDRESS** if Different from Patient: ☐ same

______________________________________________________

______________________________________________________

**NAME OF PERSON & PHONE NUMBER IN THE EVENT OF AN EMERGENCY (Someone NOT living at the same home address):**

**PRIMARY CARE DOCTOR** (*first and last name*): ______________________________________________

**PHONE** (_____________)______________________________________

**COMPLETE MAILING ADDRESS**: ______________________________________________________

STREET SUITE# CITY STATE ZIP

**NAME and PHONE # of PHARMACY:** ______________________________________(________)__________________________

**Initial here if you allow us to send you text messages regarding studies** _______________
*Initials*

**By signing this form, I am confirming that the above information is correct as of the date below.**

**SIGNATURE:**____________________________________________________________ **DATE:** __________________________

R/U____________ R/U____________ R/U____________ R/U____________ R/U____________ R/U____________ R/U____________

R/U____________ R/U____________ R/U____________ R/U____________ R/U____________ R/U = Reviewed and Updated, Date and Initial