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

OTHER FAMILY MEMBERS WHO ARE PATIENTS?

_____

Are patient's biological parents separated or divorced? ☐ YES ☐ NO

If patient's parents are separated or divorced, who has custody:

LEGAL: ☐Shared ☐Father* ☐Mother* ☐Other:_____

PHYSICAL: ☐Shared ☐Father* ☐Mother* ☐Other:_____

** If legal custody is not shared, please submit a copy of custody agreement*

BIOLOGICAL MOTHER INFORMATION

NAME: _____

eMAIL: _____

PHONE: _____

MAILING ADDRESS

_____

_____

BIOLOGICAL FATHER INFORMATION ☐NA/Unknown

NAME: _____

eMAIL: _____

PHONE: _____

MAILING ADDRESS

_____

_____

LEGAL GUARDIAN INFORMATION ☐NA

NAME: _____

eMAIL: _____

PHONE: _____

MAILING ADDRESS

_____

_____

LEGAL GUARDIAN INFORMATION ☐NA

NAME: _____

eMAIL: _____

PHONE: _____

MAILING ADDRESS

_____

_____

NAME OF PERSON & PHONE NUMBER IN THE EVENT OF AN EMERGENCY:

_____

PRIMARY 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:** _____

Signature of Biological Father / Biological Mother / Legal Guardian (Circle One)

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	