Kern Allergy and Medical Research
2116 17th Street
Bakersfield, CA 93301
661-864-7710

Name: _____ **Date Of Birth:**_____

Address: _____**City/State:**_____ **Zip:** _____

Home Phone: (____)_____ **CA ID # :**_____

Email Address: _____

Occupation: _____ **Address**_____

Work Phone: (___)_____

Primary Care Physician: _____ **Address:**_____

Phone no: (_____)_____

Pharmacy: _____ **Address:**_____

Phone no: (_____)_____

Friend/Relative not living in home:_____ **Phone #:** (____)_____

Address: _____**City/State:** _____**Zip:** _____

Emergency Contact: _____ **Relationship Type:** _____
Phone #: (____)_____

Address:_____**City/State:**_____**Zip:**_____

How Would You Like Us To Notify You Of An Upcoming Appointment?

☐ **TEXT ME:**_____

☐ **CALL ME:**_____

☐ **EMAIL ME:**_____

(Please Fill Out Back)

Parent/Legal Guardian Information (Please fill out if under 18 years of age)

Mother's Name:_____ **Cell phone:(___)**_____

Address (if same as minor's please put "same"):_____

Occupation:_____ **Address:**_____

Work phone: (____)_____

Father's Name: _____ **Cell phone:(____)**_____

Address (if same as minor's please put "same"):_____

Occupation:_____ **Address:**_____

Work phone: (____)_____

Medical Information:

Are you currently taking prescription medications? ☐ YES ☐ NO

Are you currently taking non-prescription medications? ☐ YES ☐ NO

Are you Allergic to any Medications? ☐ YES ☐ NO

Have you ever smoked/used Tobacco?

☐ Never used tobacco ☐ Current tobacco user ☐ Former tobacco user

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How did you hear about us? _____

Would you like to be notified about other studies? ☐ YES ☐ NO

_____ _____

Signature of Subject Date

_____ _____

Signature of Parent/Legal Guardian (If Under 18 Years of Age) Date