DATE: ___/____/____

REGISTRATION FORM

I HAVE: (Please Circle One)

Asthma	COPD	Skin Infection	Urticaria	Primary Care Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
If you're under the age of 18, list parents name below: Last Name:	First:	Middle:			Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth date: / /	Age:	Sex: ❑ M ❑ F

RACE:

☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian Or Other Pacific Islander

☐ Asian ☐ White ☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic Or Latino

☐ Decline to Specify

Primary Language:

Street address:	**Email Address:**	**CIRCLE ONE:** Home/Cell phone number: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

How Did You Find Out About Us?

☐ **Family** ☐ **Friend** ☐ **Other** ☐ **TV ad** ☐ **Facebook** ☐ **Dr.**

Would you like to receive our weekly emails?

☐ **YES, Email Address:** _____

☐ **NO**

MEDICAL INFORMATION

(Please give the list of medications to the receptionist)

Are you currently taking any prescription medications? ☐ **Yes** ☐ **No**	Are you currently taking any non- prescription medications? ☐ **Yes** ☐ **No**
Are you allergic to any medications? ☐ **Yes** ☐ **No**	Have you ever smoked/used Tobacco? ☐ **Yes (Current)** ☐ **No** ☐ **Previously**

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )

The above information is true to the best of my knowledge.

x _____ x _____

Patient/Guardian signature *Date*