ARACELI ELIZALDE, MD
Board Certified Adult & Pediatric Allergist and Immunologist

Patient Registration

DATE: _____________________________

FIRST NAME _______________________ MIDDLE NAME: ___________ LAST NAME: _________________

DOB ______________________ LEGAL SEX: M / F

ADDRESS____

CITY: ____ STATE: ________________ ZIP: __________

HOME PHONE (_____) _______________________________

WORK PHONE (_____) ____________________ MOBILE PHONE _________________________________

CONSENT TO AUTOMATED CALLS/TEXT ALERTS (i.e. APPOINTMENT REMINDERS, HOLIDAY SCHEDULE, LAB RESULTS, ETC.) □ YES □ NO

EMAIL ADDRESS____

MARITAL STATUS _________________ ETHNICITY ________________ LANGUAGE: _________________

EMERGENCY CONTACT NAME: ____

RELATIONSHIP TO PATIENT: ____

HOME PHONE: (_____) ____________________________MOBILE PHONE: (_____) __________________

INSURANCE INFORMATION:

INSURANCE CARRIER ____

POLICY HOLDER_________________________ DOB ___________ GROUP ID ______________________

MEMBER NUMBER _______________________ EMPLOYER NAME _______________________________

SECONDARY INSURANCE ____________________________ GROUP ID ___________________________

POLICY HOLDER___________________________ DOB _______________________________________

MEMBER NUMBER _______________ EMPLOYER NAME _______________________________________

GUARANTOR (PERSON RESPONSIBLE FOR ACCOUNT): _______________________________________

SS#________________________________ DRIVER'S LICENSE #_________________________________

RELATIONSHIP TO PATIENT __________________________

PHONE NUMBER (_____) _____________________________

ADDRESS (if different from patient) ____