Allergy & Asthma
TEXAS HEALTH
Together we can!

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

NEW PATIENT REGISTRATION

DATE: _____

FIRST NAME: _____ MIDDLE NAME: _____

LAST NAME: _____

DOB: _____

LEGAL SEX: M / F

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ MOBILE PHONE _____

WORK PHONE: (_____) _____

CONSENT TO AUTOMATED CALLS/TEXT ALERTS (I.E. APPOINTMENT REMINDERS, HOLIDAY

SCHEDULE, LAB RESULTS, ETC.) ☐ YES ☐ NO

EMAIL ADDRESS: _____

MARITAL STATUS: _____

LANGUAGE: _____ RACE: _____ETHNICITY: _____

OCUPATION: _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____

HOME PHONE: (_____) _____MOBILE PHONE: (_____) _____

GUARANTOR (PERSON FINANCIALLY RESPONSIBLE): _____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

PHONE NUMBER (_____) _____

DRIVER'S LICENSE #_____ SS#_____

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INSURANCE INFORMATION:

PRIMARY INSURANCE CARRIER:_____

NAME OF POLICY HOLDER: _____ GROUP ID: _____

MEMBER ID NUMBER: _____

EMPLOYER NAME: _____

SECONDARY INSURANCE CARRIER:_____

NAME OF POLICY HOLDER: _____ GROUP ID: _____

MEMBER ID NUMBER: _____

EMPLOYER NAME: _____

IMPORTANT: IF YOU HAVE 2 INSURANCE CARRIERS, THE PATIENT MUST NOTIFY EACH CARRIER ABOUT THE OTHER INSURANCE PLAN SO THAT BOTH PLANS CAN WORK TOGETHER TO PAY CLAIMS FOR THE SAME PERSON. THIS IS CALLED COORDINATION OF BENEFITS.

NEW PATIENT CLINICAL INTAKE

NAME OF YOUR PRIMARY CARE DOCTOR: _____

PREFERRED PHARMACY: _____

PREFERRED LAB: _____

HOW DID YOU HEAR FROM US? _____

REASON FOR VISIT: _____

MEDICATION ALLERGIES: _____

_____

MEDICAL PROBLEMS: _____

_____

ARE YOUR SHOTS UP TO DATE? _____

MEDICAL FAMILY HISTORY (IMMEDIATE FAMILY MEMBERS): _____

_____

PETS (DOG/CAT/OTHER, NUMBER, INSIDE/OUTSIDE): _____

TOBACCO SMOKE USE OR EXPOSURE: YES/NO

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WHAT TYPE OF FLOORING AT HOME? _____

SURGERIES: _____

_____

LIST ALL MEDICATIONS, SUPPLEMENTS, INFUSIONS YOU TAKE. HAVING A CURRENT AND ACCURATE MEDICATION LIST IS EXTREMELY IMPORTANT FOR YOUR SAFETY. WE NEED TO KNOW THE FOLLOWING FOR EACH MEDICINE:

- NAME
- STRENGTH
- DIRECTIONS
- START DATE
- PRESCRIBER

_____

_____

_____

_____

_____

_____

_____

_____

IMPORTANT REMINDER

FOR ANY ALLERGY TESTING PLEASE STOP ANTIHISTAMINES 5 DAYS PRIOR TO APPOINTMENT I.E. ALLEGRA, ZYRTEC, BENADRYL, XYZAL, HYDROXYZINE, ETC.

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