Kern Allergy Medical Clinic, INC
Tonny Tanus, M.D. Eric J Boren, M.D.
Darryl Altavas, FNP
New Patient Information

Please Print Clearly

PATIENT First Name__________________ Middle Initial ____ Last Name___________________ Gender_______ Date of birth ____/____/_____

Marital Status: M____S____W____D____ Race: __________________ Ethnicity: ___________________

Social Security # ________-_______-________ * ***Required or Credit Card will be ask to be kept on file for billing purposes****

Language_______________________ Home Phone #_______-______-_______ Cell phone_____-______-_______ Preferred Phone (Circle): Home / Cell

Home Address____ City________________________ State_____ Zip Code___________

Email Address____ Primary Physician: __________________ Referring Physician: _____________________

Preferred Pharmacy____ Cross Street______________________________

Insurance

Primary Insurance _____________________________

Policy #: ________________________ Group #: ______________________

Subscriber Name: _____________________ DOB: _____/______/______

Social Security _____ -_____-______ Relationship to patient: _____________

Secondary Insurance: _______________________________

Policy #: ____________________ Group #: __________________

Subscriber Name: _____________________ DOB: ______/_____/______

Social Security _____ - ______-______ Relationship to patient ___________

Please complete if patient is a minor/student

Mother (Or Guardian) Information If Legal Guardian, relationship to patient____

First Name__________________________________ Middle initial_______ Last Name____

SS#______________________________ Date of birth____/____/_______ Home Phone # ______________________ Cell Phone #_______________________

Home Address____ City___________________________ State_________ Zip code_____________

Employer____ Occupation____________________________ Work Ph #_____________________

Father (Or Guardian) Information If Legal Guardian, relationship to patient____

First Name__________________________________ Middle initial_______ Last Name____

SS#______________________________ Date of birth____/____/_______ Home Phone # ______________________ Cell Phone #_______________________

Home Address____ City___________________________ State_________ Zip code_____________

Employer____ Occupation____________________________ Work Ph #_____________________

HIPPA contacts: Authorization to Release Protected Health Information to the following individuals

Name: ____ Phone # _______-________-____________ Relationship_____ ______________________

Name: ____ Phone # _______-________-____________ Relationship_____ ______________________

Name: ____ Phone # _______-________-____________ Relationship_____ ______________________

____ ____________________________________

Signature of Patient or Parent/Guardian/Responsible Party Date