Kern Allergy Medical Clinic, INC
Tonny Tanus, M.D. Eric J Boren, M.D.
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