

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