

Louisiana Allergy & Asthma Specialists

Benjamin B. Close, MD

Rebecca Brady, MSN, APRN, FNP-C

David Mickey, MD

Patient's Name _____

Address _____

City _____ State _____ Zip Code _____

Patient's Gender: Male Female Other Social Security # _____

Date of Birth _____ Race _____

Cell # _____ Work # _____ Home # _____

Email _____

Patient's Employer _____

Spouse's Name _____

Marital Status: S M W D Spouse's Date of Birth _____

Spouse's SS# _____ Spouse's Cell # _____

Primary Care Provider _____

Referred by: Doctor/Health Care Provider _____

Pharmacy _____ Location _____

Emergency Contact _____ Relationship _____

Phone # _____

PLEASE FILL OUT THIS PAGE IF PATIENT IS A CHILD/MINOR

Mother's Name _____ Date of Birth _____

Mother's Employer _____ Work # _____

Father's Name _____ Date of Birth _____

Father's Employer _____ Work # _____

SS# (Mother) _____ (Father) _____

Additional Persons Who May Bring Child/Minor to Visits/Consent to Medical Care:

Name _____ Relationship to Patient _____

Phone _____

Name _____ Relationship to Patient _____

Phone _____

Additional Contact Questions:

Who should receive billing statements? Name and Address:

May all contacts have access to the patient's records? Yes / No

If parents are divorced, separated, or unmarried, please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment?
Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.
