<u>Louisiana Allergy & Asthma Specialists</u>

Benjamin B. Close, MD

Rebecca Brady, MSN, APRN, FNP-C

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 # __________________

201 Pecan Park Avenue, Alexandria, LA 71303
(318) 445-6221 / (318) 445-5399 (fax)

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.

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