		For Official Use Only				
PLEASE PRINT		Patient #		Location_	-	Photo ID Verified
		Date of First A	ppointment			
PATIENT INFORM	ATION	L				
Patient's Name:					Home Phor	ne #
						#
Address:	Street	City		State Zip	Best numb	er for messages:
E-Mail Address:						Home 🖵 🛛 Cell 🕻
Date of Birth:	SEX: Male 🖵	Female 🖵 🛛 Rela	ationship Status:		Social Secu	urity #
			-			
EMERGENCY CON	NTACT:		Relati	ionship:	Conto	act Phone #
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	-				Phone (1
Primary Care Physician:)
Address:	Street	City	Stat	te Zip	Fax # ()
Specialist/Other:					Phone ()
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I understand and agree if care at Colorado Allergy and Asthma Centers requires Primary Care Physician referral, it is my responsibility to see that the referral is current prior to receiving care at Colorado Allergy and Asthma Centers. If no referral is present in advance, I agree to pay for charges at the time of service. ardian Signature _ _

Patient/Guardian	Sig
Witness	

Relationship	to	Patient_	
Date			

Consent for care of minors Because my son/daughter is a minor (less than eighteen (18) years of age) and primarily supported by parent or guardian, I understand and agree that he/she may be evaluated and/or treated by Colorado Allergy and Asthma Centers' staff if I am not present to give consent. This may include, but necessarily limited to, physical exams, skin tests, laboratory test, allergy injections and the prescription of medications in my absence. This agreement will be in effect until revoked by me in writing.

Signature	
Witness	

Relationship to Patient_

Date