Rand E. Dankner, M.D.
Jacqueline L. Reiss, M.D.

ALLERGY
ASSOCIATES, INC.

Please print when filling out this form

PATIENT INFORMATION Date: _____/_____/_____ (if new patient, date of first appointment)

Patient's Name: _____ Age: _____
(Last) (Middle) (First)

Address: _____
Street City State Zip

Phone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Email Address: _____ Social Security #: _____
Your email address is protected by and only used by Allergy Associates, Inc operations

Date of Birth: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Have you or other family members received medical care by our practice? Who? _____ When? _____

PHYSICIAN INFORMATION

Primary Care Physician (PCP): _____ Phone: _____

Address: _____

Specialist: _____ Phone: _____

Address: _____

I give my permission to send a written report(s) to the above Doctors: ☐ Yes ☐ No

---

REFERRAL SOURCE
How did you hear about Allergy Associates, Dr. Dankner, or Dr. Reiss?

☐ Referred by a physician: Physicians name: _____

☐ Referred by family member or friend who has received care from our practice: _____

☐ Other: _____

EMPLOYMENT INFORMATION

Complete this area for the patient OR parent/guardian of a minor

Name: _____ Relationship: _____

Date of Birth: _____ SSN#: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip: _____

Complete this area for the spouse OR the 2nd parent/guardian of a minor

Name: _____ Relationship: _____

Date of Birth: _____ SSN#: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip: _____

INSURANCE

PRIMARY INSURANCE

Name of Insurance plan: _____

Name of the person who carries insurance: _____

Insurance Identification Number: _____

Group Number: _____

Date Insurance began: _____ Copay $_____

SECONDARY INSURANCE

Name of Insurance plan: _____

Name of the person who carries insurance:_____

Insurance Identification Number: _____

Group Number: _____

Date Insurance began: _____ Copay $_____

BILLING PROCEDURE

I authorize the release of any medical or other information necessary to process insurance claims for services received from Allergy Associates, Inc. I also request payment of government benefits to myself or to the party who accepts assignment. I understand I am financially responsible for charges not covered by this authorization. I understand and agree if care at Allergy Associates, Inc requires Primary Care Physician referral; it is my responsibility to see that the referral is current prior to receiving care at Allergy Associates, Inc. If no referral is present in advance, I agree to pay for charges at the time of service.

Signature _____ Relationship to Patient _____

Consent for care of minors: Because my son/daughter is a minor (less than 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 Allergy Associates, Inc staff if I am not present to give consent. This may include, but not necessarily be limited to, physical exams, skin tests, laboratory tests, allergy injections, and the prescription of medications in my absence. This agreement will be in effect until revoked by me in writing.

Signature _____ Relationship to Patient _____

Chesterfield Office: 1570 Woodlake Drive, Chesterfield MO 63017 Phone: (314) 878-0996
St. Peters Office: 4601 Executive Centre Parkway, Suite 100, St. Peters MO 63376 Phone: 636) 928-3344
https://www.allergyassociatesinc.com/