***** PLEASE RETURN AS *****
***** SOON AS POSSIBLE *****

PHYSICIAN:
- ☐ Eddie W. Shields, M.D.
- ☐ Lori M. Kagy, M.D.
- ☐ Kelly D. Burks, M.D.
- ☐ Nancy W. Zuerlein, M.D.

ARKANSAS ALLERGY & ASTHMA CLINIC, PA

A Tradition of Quality Patient Care Since 1930

FOR OFFICE USE ONLY:
Patient #: _____
APPOINTMENT:
Day: _____
Date: _____
Time: _____
CLINIC:
☐ Little Rock ☐ Conway

NEW PATIENT PRE-REGISTRATION FORM

PATIENT INFORMATION:

Name: _____
Last First Middle

Patient's Social Security No.: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone (Area Code): _____

Cell Phone (Area Code): _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Email Address:_____

REFERRING PHYSICIAN:

Name of physician that recommended you see an allergy/asthma specialist for evaluation. ☐ NONE

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

PRIMARY CARE PHYSICIAN:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

PATIENT EMPLOYER:

Employer: _____

Business Phone (Area Code): _____

SPOUSE:

Name of Spouse: _____

Date of Birth: _____

Spouse's Social Security No.:_____

Spouse's Employer: _____

IF PATIENT IS A MINOR:

Father's Name: _____ D.O.B.: _____

Father's Employer: _____

Father's Social Security No.: _____

Business Phone (Area Code): _____

Mother's Name: _____ D.O.B.: _____

Mother's Employer: _____

Mother's Social Security No.: _____

Business Phone (Area Code): _____

EMERGENCY CONTACT (not living in same household):

Name: _____

Phone (Area Code): _____

Date of Birth: _____

Relationship to patient: _____

RACE: ☐ White/Caucasian ☐ Black/African American ☐ Hispanic ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race: _____

PHARMACY:

Local Pharmacy: _____

Location: _____