Wexford Allergy, Asthma & Immunology, LLC
100 Bradford Road, Suite 410, Wexford, PA 15090
Phone (724)719-2441 / Fax (724)719-2451
www.wexfordallergy.com

Established Patient Registration Form

Name ______________________________________ Today's date ____________

Address ________________________ City __________ State _____ Zip code ______

Home phone ____________ Cell phone ______________ Email ________________

Birth date ___________ Sex M/F Marital status ______ Social security # ____________

Occupation & employer/school ______________________ Race/Ethnicity ____________

Referring physician ________________ Primary care physician ________________

Preferred pharmacy name & phone # __________________ Mail order pharmacy ____________

What is the reason for your visit today?

If you have been given a diagnosis by another physician, please specify it here, as well as the diagnosis code if known.

PAYMENT AND INSURANCE INFORMATION

Please note that we will need to copy your photo ID and insurance card.

Primary Insurance ______________________ Member ID# ______________________

Group name ______________________ Group/Plan # ______________________

Policy holder/Subscriber name ______________________ Relationship to patient ________

Policy holder/Subscriber birth date ______________ Phone number ______________

Policy holder/Subscriber address ____

Secondary Insurance (if applicable) ______________ Member ID# ______________________

Group name ______________________ Group/Plan # ______________________

Policy holder/Subscriber name ____________ Relationship to patient ________ Birth date ________

Financially responsible party

If the patient is a minor, to whom should bills be sent? Name ______________________

Relationship to patient __________ Date of birth __________ Phone number __________

Address ________________________ City __________ State _____ Zip code ______

Phone (724)719-2441 / Fax (724)719-2451
www.wexfordallergy.com

MEDICATIONS **Patient name** ____________________________

Please list your current medications and doses.

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

REVIEW OF SYSTEMS – Are you **currently** experiencing any of the following symptoms?

GENERAL	MOUTH/THROAT	MUSCULOSKELETAL
○ **Fever** ○ **Chills** ○ **Fatigue**	○ **Itchy throat** ○ **Sore throat** ○ **Frequent throat clearing** ○ **Hoarseness**	○ **Muscle pain** ○ **Joint pain** ○ **Joint stiffness** ○ **Joint swelling** ○ **Joint redness/warmth**
EYES	**NECK**	**SKIN**
○ **Red** ○ **Watery** ○ **Itchy** ○ **Swelling**	○ **Lumps**	○ **Rash** ○ **Hives** ○ **Itching** ○ **Flaking/peeling** ○ **Swelling** ○ **Redness/flushing**
EARS	**RESPIRATORY**	**NEUROLOGIC**
○ **Pain** ○ **Fullness/popping** ○ **Itching**	○ **Cough** ○ **Wheeze** ○ **Difficulty breathing** ○ **Chest tightness** ○ **Trouble with exercise**	○ **Headache** ○ **Dizziness/vertigo**
NOSE	**GASTROINTESTINAL**	**PSYCHIATRIC**
○ **Stuffy/congested** ○ **Itchy** ○ **Runny** ○ **Sneezing** ○ **Loss of sense of smell** ○ **Post-nasal drip** ○ **Sinus pressure** ○ **Nosebleeds**	○ **Stomach pain** ○ **Heartburn** ○ **Nausea** ○ **Vomiting** ○ **Diarrhea** ○ **Constipation**	○ **Stressors** ○ **Sleep disturbance**