Louisiana Allergy & Asthma Specialists
Benjamin B. Close, MD
Carol A. Netherland, CNP

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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