



# PATIENT REGISTRATION

Please print and complete all parts

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Have you or any other family member been treated by Dr. Mayer?  Yes  No Name: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Nickname

Social Security # \_\_\_\_\_ Maiden/Former Name: \_\_\_\_\_

Sex:  M  F Date of Birth: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Address: \_\_\_\_\_

PCP Phone: \_\_\_\_\_

How did you hear about our office: \_\_\_\_\_

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Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Insured's SSN: \_\_\_\_\_ Insured's SSN: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

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