New England Food Allergy Treatment Center LLC

Patient Information

Patient's Name: _____ **Today's Date**: _____
Last First Middle Initial

Address: _____ Male / Female
Street Apt/PO Box

_____ Home Phone: (_____) _____- _____
Town State Zip Code

Patient's Date of Birth: _____/_____/_____ Age: _____ **Best Email**_____

Parent #1 Name: _____ Male / Female
Last First Middle Initial

Address: _____ Home Phone: (_____)_____-_____
Street Apt/PO Box

_____ Cell Phone: (_____) _____- _____
Town State Zip Code

Parent #2 Name: _____ Male / Female
Last First Middle Initial

Address: _____ Home Phone: (_____)_____-_____
Street Apt/PO Box

_____ Cell Phone: (_____)_____- _____
Town State Zip Code

Primary Insurance

Patient Insurance:_____/_____/_____/_____
Plan Name Policy Holder ID Number Group Number

Policy Holder Name: _____
Last First Middle Initial

Policy Holder Date of Birth _____/ _____ /_____ Male / Female

Address: _____
Street Apt/PO Box

_____ Home Phone: (_____)_____- _____
Town State Zip Code

Secondary Insurance

Secondary Insurance:_____/_____/_____/_____
Policy Holder Name **Policy Holder Date of Birth** **ID Number** Group Number

Pharmacy of Choice _____ Phone _____

Primary Care Physician: _____
Name Address

Referring Physician/Person: _____
Name Address

Patient's Signature:_____ Today's Date:_____

By Signing below, I agree that information can be shared with insurance company in purposes of NEFATC receiving payment directly from participating insurance carrier.

Parent's Signature:_____ Today's Date:_____