



ROBERT D. COOK, M.D., P.A.  
 DIPLOMATE AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY

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TODAY'S DATE:		<b>PATIENT INFORMATION</b>			
FIRST NAME		MI	LAST NAME		DOB
ADDRESS			CITY	STATE	ZIP
HOME PHONE	WORK PHONE	OTHER / BEEPER / MOBILE		E-MAIL	
SS#	DL#	SEX: M( ) F( )	AGE	MARITAL STATUS S( ) M( ) W( ) SEP( ) D( )	
PATIENT'S EMPLOYER		WORK FULL TIME? Y( ) N( )		FULL TIME STUDENT? Y( ) N( )	
BUSINESS ADDRESS				OCCUPATION	

REFERRED BY		ADDRESS (IF MD)	
PRIMARY CARE PHYSICIAN		ADDRESS	
IN CASE OF EMERGENCY, NOTIFY		WORK/CELL PHONE	RELATIONSHIP TO PT
SPOUSE'S NAME	DOB	WORK/CELL PHONE	EMPLOYER

PRIMARY INSURANCE COMPANY NAME		
NAME OF POLICY HOLDER	RELATIONSHIP TO PATIENT	POLICY HOLDER SS #
CERTIFICATE OR POLICY #	GROUP #	POLICY HOLDER DOB
SECONDARY INSURANCE COMPANY NAME (Circle <b>NONE</b> IF NOT APPLICABLE)		
NAME OF POLICY HOLDER	RELATIONSHIP TO PATIENT	POLICY HOLDER SS #
CERTIFICATE OR POLICY #	GROUP #	POLICY HOLDER DOB

**IF PATIENT IS A MINOR OR A FULL TIME COLLEGE STUDENT:**

MOTHER'S NAME		DOB	SS #
HOME ADDRESS		CELL PHONE	HOME PHONE
OCCUPATION	EMPLOYER		WORK PHONE
FATHER'S NAME		DOB	SS #
HOME ADDRESS		CELL PHONE	HOME PHONE
OCCUPATION	EMPLOYER		WORK PHONE

RESPONSIBLE PARTY FOR PAYMENT (please circle)  
 SELF, MOTHER, FATHER, OTHER (If Other, list Name, Relationship to Patient, Phone & Address)

In order to control our costs of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees.

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**SIGN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_