Allergy & Asthma Care of Manhattan, PLLC
30 East 40th St Suite 802
New York, NY 10016
Tel 212-481-1744 Fax 212-685-0625
allergycare@gmail.com
www.nyallergycare.com

Mariana Marcu, MD.
Allergy & Asthma
Care of Manhattan, PLLC

PATIENT INFORMATION

First Name: _____ MI____ Last Name_____

Date of Birth: _____ Age: _____ Sex: _____ SS#:_____

Marital status_____ Address: _____

Apt#:_____ City_____ State_____ Zip code: _____

Occupation: _____Employer name_____

Employer address_____ Work No. _____

Race: _____ Ethnicity: _____ Language: _____

How did you hear about us? _____ Email: _____

Home Phone No. _____ Cell Phone No._____

Permitted contact method: Phone Email Mail (circle all that apply)

INSURANCE INFORMATION

Primary INS Name: _____ Policy Holder name: _____

Policy Holder DOB: _____ Policy Holder SS#:_____

Member Id: _____ Group No. _____

Secondary INS Name: _____ Policy Holder name_____

Policy Holder DOB: _____ Policy Holder SS#: _____

Member Id: _____ Group No. _____

EMERGENCY INFORMATION:

Person to Notify in case of emergency: _____

Relationship: _____ Contact number: _____

Address: _____

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Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans require copayment at the time of service.

Patient/ Guarantor Signature_____ **Date**_____

PHARMACY INFORMATION

Preferred Pharmacy name: _____ Address: _____

City: _____ State: ____Phone: _____ Zip code: _____

PATIENT MEDICAL HISTORY FORM

Name: _____ Age: _____ Date_____

Primary Physician name: _____ Phone No. _____

Address: _____

Other Specialists (Name and specialty): _____

Medical Problems (Including present condition): _____

_____

_____

_____

List all current prescriptions medicines (include dosage, reason you take it and who prescribed it: _____

_____

_____

_____

Allergies to medications: _____

_____

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List Surgeries or hospitalization you have had (Include year)

_____

_____

_____

Do/ did you smoke? YES NO How much? _____ Packs/day # of years___

Do/ did you drink Alcohol: _____? How many _____drinks/weeks

Anything else you would like us to know? _____

_____