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: _____

INFORMATION FOR THE PATIENT

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**_____

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

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: _____

_____

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? _____

_____