FAIRFIELD COUNTY ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.
ADULT AND PEDIATRIC ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY
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EMR Info Sheet

Patient's Name: _____ DOB: _____

Parent E-Mail Address: _____

Race: Asian ☐ Black ☐ Hispanic ☐ White ☐ *(pick one)*

Language: English ☐ Sign Language ☐ Spanish ☐ Other ☐

Ethnicity: Latino ☐ Non-Latino ☐ Refuse to Answer ☐

Primary Care Provider: _____

Best Contact Number: _____

Primary Pharmacy – **PLEASE BE AS SPECIFIC AS POSSIBLE WITH LOCATION**

Pharmacy Name: _____

Street: _____

Town: _____ Phone Number: _____

Allergies _____ None ☐

Current Medications: _____

Any new family health/history?

_____

_____

Any mental health/substance abuse issues _____

Any communication issues (blind, language, etc.)

Any family, social or cultural issues _____

Signature: _____ Date: ____/____/____