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

Patient's Name: _____ DOB: _____

Patient eMail Address: _____

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

Language: English ☐ Sign Language ☐ Spanish ☐ Other ☐

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

Primary Care Provider: _____

Best Contact Number: _____

Primary-Pharmacy – PLEASE BE SPECIFIC AS POSSIBLE WITH LOCATION

Pharmacy Name: _____

Street: _____

Town/City: _____ 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 _____