DIPLOMATE
AMERICAN BOARD OF INTERNAL MEDICINE
AMERICAN BOARD OF ALLERGY & IMMUNOLOGY

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Asthma, Allergy & Immunology

METROPOLITAN PROFFESIONAL BUILDING - SUITE 362
1303 McCULLOUGH AVENUE
SAN ANTONIO, TEXAS 78212

DATE_____

NAME_____
ADDRESS_____
CITY_____ZIP CODE_____
TELEPHONE_____BIRTHDATE_____SEX_____
SINGLE_____MARRIED_____WIDOWED_____DIVORCED_____
OCCUPATION_____EMPLOYED BY_____
EMPLOYER'S ADDRESS_____
BUSINESS PHONE_____EXT_____CELL PHONE_____
E-MAIL ADDRESS_____
CONTACT PREFERENCE_____
INSURED'S NAME (if same mark SAME) _____
ADDRESS_____CITY_____ZIP CODE_____
TELEPHONE_____BIRTHDATE_____RELATION_____
OCCUPATION_____BUSINESS PHONE_____
EMPLOYED BY_____
EMPLOYER'S ADDRESS_____
SOCIAL SECURITY NO._____DRIVER'S LIC._____
INSURANCE CO._____INSURED'S DOB_____
POLICY #_____GROUP#_____
PATIENT REFERRED BY_____
PATIENT'S PHYSICIAN_____
PATIENT'S SOCIAL SECURITY NO._____
DRIVER'S LICENSE NO._____
EMERGENCY CONTACT_____PHONE NO._____
RELATIONSHIP:_____

HEALTH QUESTIONS:

Is your general health good? YES____ NO____
Are you under a physician's care now? YES____ NO____
Have you ever had heart trouble, rheumatic fever, diabetes or infectious hepatitis? YES____ NO____
Have you ever had trouble with bleeding after surgery? YES____ NO____
Have you ever had an unusual reaction to any drug or local anesthetic? YES____ NO____
Is there any other information about your health which should be known? YES____ NO____

I directly assign all medical benefits to Michel N. Laham, M.D. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

How did you hear about us? You may answer more than one if they apply.
Physician____ Other Patients____ Phonebook____ Online Evaluation____
Insurance Provider List____

SIGNATURE_____DATE_____