NARBERTH ALLERGY & ASTHMA

Narberth Allergy and Asthma

Corinna Bowser, MD
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Name: _____ **DOB:** _____

Home/daytime contact phone number:_____

May we leave a message with other residents? _____ Yes _____ No

May we leave a message on your home answering/voicemail? _____ Yes _____ No

To whom may we talk to about your medical treatment?

1. Name _____ Relationship _____

Home Phone No. _____ Cell No. _____

Other Phone No. _____

Is this person an emergency contact also? _____ Yes _____ No

2. Name _____ Relationship _____

Home Phone No. _____ Cell No. _____

Other Phone No. _____

Is this person an emergency contact also? _____ Yes _____ No

If any of the above information changes, it is the Patient/Parent/Legal Guardian's responsibility to contact our office.

Patient/Parent/Legal Guardian Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge that I was offered a copy of the Notice of Privacy Practices (HIPAA) and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Patient/Parent/Legal Guardian Signature _____Date _____

CONSENT TO OBTAIN PRIOR MEDICATION HISTORY FROM THIRD PARTY (surescripts)

I herewith consent for Narberth Allergy to obtain my medication history as available from third party (my pharmacy and surescripts).

Patient/Parent/Legal Guardian Signature _____Date _____