ALLERGY, ASTHMA, AND CLINICAL IMMUNOLOGY SPECIALISTS, P.C.
REBECCA B. RABY, M.D. **HEATHER C. JAMES, M.D.**

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Request for a Specialty Clinic Appointment

*****OUR PHYSICIANS DO NOT ACCEPT PATIENT FAMILIES UNWILLING TO ADHERE TO THE CDC IMMUNIZATION SHEDULES.*****

If your patient's insurance/demographic information is available from your records, a copy of that will be appreciated.

***** Please fill out form completely and send all records pertaining to reason for a visit or it may delay scheduling! *****

PATIENT DEMOGRAPHICS

REASON FOR REFERRAL: ______________________________

PATIENT NAME: ______________________ DOB: __________ SEX: ____ RACE: __________

SSN: ______________ ADDRESS: ______________________________
STREET CITY STATE ZIP

PHONE: ______________ / ______________ / ______________
CHECK PREFERRED CONTACT NUMBER HOME ☐ CELL ☐ WORK ☐

INSURANCE INFORMATION

Attach a legible copy of insurance card(s) and insurance referrals (if required)!

PERSON RESPONSIBLE FOR BILLING/GUARANTOR RELATIONSHIP TO PATIENT DOB

PRIMARY INSURANCE COMPANY

PRIMARY POLICY NUMBER GROUP NUMBER

CARD HOLDER'S NAME DOB ADDRESS (IF DIFFERENT FROM ABOVE)

SECONDARY INSURANCE COMPANY (IF APPLICABLE)

SECONDARY POLICY NUMBER GROUP NUMBER

CARD HOLDER'S NAME DOB ADDRESS (IF DIFFERENT FROM ABOVE)

REFERRING PHYSICIAN INFORMATION

NAME: ______________________ NPI: ______________

PHONE: ______________ CONTACT PERSON/EXT: ______________

FAX: ______________ PCP (IF DIFFERENT FROM REFERRING DOCTOR): ______________

HAS THE PATIENT BEEN EVALUATED AT OUR OFFICE BEFORE? (CIRCLE ONE) YES / NO

INTERPRETER NEEDED? (CIRCLE ONE) YES / NO

PREFERRED PHYSICIAN: (CIRCLE ONE) RABY JAMES 1ST AVAILABLE

****THIS BOX IS TO BE FILLED OUT BY AACIS****
PLEASE NOTIFY THE ABOVE REFERENCED PATIENT OF APPOINTMENT WITH:
RABY / JAMES ON ______________ AT __________
PLEASE LET PATIENT KNOW TO STAY OFF ALL ANTIHISTAMINES FOR 5 DAYS PRIOR TO APPOINTMENT.
DATE/TIME FAXED BACK: ______________