Patient Information

SANTA FE CENTER FOR ALLERGY AND ENVIRONMENTAL MEDICINE

W.A. SHRADER, JR. MD

***** Please understand that you need to give us 24 hours' notice if you cannot make your appointment. You will be charged $100.00 if you miss your initial appointment without notice.**

Today's Date: _____ E-Mail Address _____

Name:_____

(LAST) (FIRST) (MIDDLE INITIAL)

Address_____

City:_____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell: (Please include) _____

Date of Birth: _____

Occupation_____ Employer_____

Name of emergency contact:_____ Ph:_____

Insurance carrier: _____

Policy number: _____Group/ID#:_____

Name of policy holder:_____

Relation: _____

Employer: _____

How did you hear about us: ☐ www.Drshrader.com ☐ Phone Book
☐ Friend/Relative ☐ Another Web Site ☐ Other

Referring Physician (if any) _____

Please understand that it is your responsibility to pay for services at the time they are rendered. We will provide you with the completed HCFA 1500 Form that you may send your insurance company, however, we do not file the form for you, nor do we participate with any insurance plans, Medicare or Medicaid.