

Patient Information
SANTA FE CENTER FOR ALLERGY AND
ENVIRONMENTAL MEDICINE
W.A. SHRADER, JR. MD

Today's Date: _____

Name: _____
(LAST) (FIRST) (MIDDLE)

Address _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Wk Phone: _____

Fax:(optional) _____ Cell:(optional) _____

Social Security# _____ Date of Birth: _____

Occupation _____

Employer _____

Name of emergency contact: _____

Ph: _____

Insurance

carrier: _____

Policy

number: _____ Group#: _____

Name of policy holder: _____

Relation: _____

Employer: _____

How did you hear about us: New Mexican Alb. Journal
 Phone Book Other

Please understand that it is your responsibility to pay for services at the time they are rendered. We will provide you with information for your insurance company, however we do not file insurance forms nor do we participate with any insurance plans