ALL AMERICAN ALLERGY, ASTHMA & IMMUNOLOGY CENTER
AAAAIC.COM

CHARLES CALAIS, D.O., M.S., FACP, FACAAI, FAAAAI
1219 McCULLOUGH AVE. SAN ANTONIO, TX 78212
Phone: (210) 226-3500 Fax: (210) 226-3638
allamericanaaic@gmail.com

DATE_____

NAME_____ DOB _____ SEX____
ADDRESS_____CITY_____ STATE____ ZIP _____
TELEPHONE_____ SSN _____
HOME PHONE_____ CELL PHONE_____
E-MAIL _____
INSURANCE _____POLICY#_____GROUP#_____
INSURED'S NAME _____ DOB _____ RELATIONSHIP _____
PCP _____ PHONE _____
EMERGENCY CONTACT_____PHONE _____ RELATIONSHIP _____
PHARMACY_____ PHONE _____
ADDRESS_____

MEDICATIONS:

NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY
NAME	STRENGTH	FREQUENCY

I directly assign all medical benefits to All-American Allergy Asthma & Immunology Center. I hereby authorize the doctors 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 select more than one if applicable.
Physician____ Other Patients____ Online ____ Insurance Provider List____ Drove By____

SIGNATURE_____DATE_____