ADVANCED ALLERGY RELIEF CENTER OF CHELMSFORD

5 Fletcher Street, Chelmsford, MA 01824 Telephone: 978-376-8190 Facsimile: 978-250 6887

Name: ____

Address: ____

City: _________________________ State: _________________ Zip: __________

Home Tel. #: __________________ Cell: ___________________ Carrier: ________

Date of birth: ______ /______ /______ Marital status: ☐ Single ☐ Married

Emergency contact & telephone #: ____

How did you hear about us? ____

E mail: ____

How would you like to be notified about appointments? ☐ E Mail ☐ Texting

Are you currently receiving health care? ☐ Yes ☐ No

If yes, name of physician: ____

Condition (s) being treated: ____

____

List current medications: ____

____

List current vitamins: ____

____

What are your most important health concerns?

1. ____
2. ____
3. ____

Please list all tested or suspected allergies and related symptoms:

Foods:____

____

Seasonal:____

____

Drug/other: ____

____

Yes, I have read and understand the Treatment Guidelines and Office Policies attached. Sign and date below when you have finished.

Signature: Date: