PIENKOWSKI, M.D.
CLINIC
ALLERGY ASTHMA IMMUNITY

NEW PATIENT PACK

We care for our community.

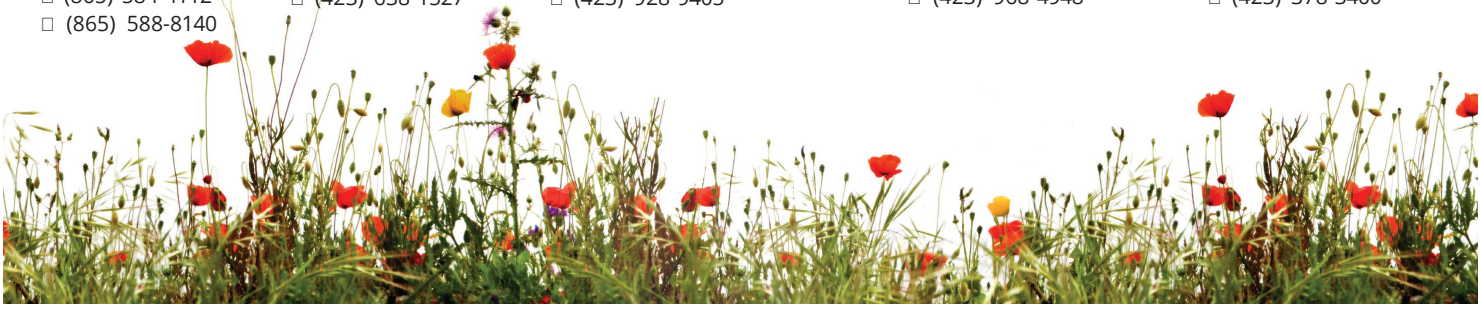
Knoxville
West Knox Plaza
7417 Kingston Pike,
Suite 101
Knoxville, TN 37919
□ (865) 584-4112
□ (865) 588-8140

Greeneville
1406 Tusculum Blvd.,
MOB 2, Suite 2500
Greeneville, TN 37745
□ (423) 638-9595
□ (423) 638-1527

Johnson City
Northside Professional Building
403 Princeton Road, Suite 4
Johnson City, TN 37601
□ (423) 928-0113
□ (423) 928-9405

Bristol
321 Midway Medical Park,
Suite 3
Bristol, TN 37620
□ (423) 968-3440
□ (423) 968-4948

Kingsport
2012 Brookside Drive,
Suite 11
Kingsport, TN 37660
□ (423) 378-3131
□ (423) 378-3400



PIENKOWSKI, M.D. CLINIC
ALLERGY ASTHMA IMMUNITY

WELCOME TO PIENKOWSKI MD CLINIC

Please take this page with you

Thank you for choosing Pienkowski MD Clinic for your allergy, asthma, and immunology care. We appreciate the trust you have placed in us and look forward to helping you achieve better health.

PATIENT ADMINISTRATIVE RESPONSIBILITIES

Insurance

- Verify coverage for allergy and immunology services with your insurance provider.
- Confirm that Allergic Diseases, Asthma & Immunology Clinic, P.C. and your physician are in-network.
- Ask whether your insurance requires a referral from your primary care physician.

Complete All New Patient Paperwork

- Patient Information Sheet – complete all sections including insurance information and referring physician.
- Allergy and Immunology Questionnaire – complete both pages carefully to assist us in evaluating your condition.
- Protected Health Information form – read, sign, and date the HIPAA acknowledgment.
- Payment Policy – read, sign, and date the payment policy form.
- Primary Care Physician Information – provide your PCP information and referral source.
- Parental Release – required for pediatric patients; list authorized individuals and sign/date.
- Patient Information Release – list anyone you authorize us to speak with regarding your care.
- Patient Cancellation Policy – read and sign the cancellation policy.

Required Personal Documentation

- Insurance cards (primary and secondary if applicable).
- A valid photo ID such as a driver's license, passport, work ID, or student ID.

PATIENT MEDICAL RESPONSIBILITIES

Restrictions Prior to Appointment

- Do not take antihistamines for at least 3 days prior to your appointment.
- Avoid over-the-counter cold preparations.
- Avoid steroids and antibiotics unless directed otherwise by your physician.
- Taking restricted medications may interfere with the accuracy of allergy testing.
- You may continue using inhalers and steroid nasal sprays.
- Bring a complete list of your medications including prescriptions, vitamins, and supplements.
- Do not wear cologne, perfume, or scented lotions as these may trigger symptoms in other patients.
- Wear comfortable clothing and a top that can be easily removed for examination.

Please allow approximately 1.5 hours for your initial evaluation.

PIENKOWSKI, M.D. CLINIC
ALLERGY ASTHMA IMMUNITY

PATIENT INFORMATION FORM

Date: _____

CONTACT INFORMATION

Name: _____ Date of Birth (DOB): _____ Acct #: _____
(For clinic use only)

Age: _____ Sex: ☐ M ☐ F ☐ Private Marital status: ☐ S ☐ M ☐ W ☐ D

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____ Business Phone: _____

Social Security: _____ Employer: _____

PARENT OF PEDIATRIC PATIENT or SPOUSE INFORMATION

Parent/Spouse Name: _____ DOB: _____ Employer: _____

Cell Phone: _____ Business Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

PRIMARY INSURANCE (Please present insurance card to receptionist)

Insurance: _____

Policyholder: _____ DOB: _____

Policyholder Address / Phone: _____

Employer: _____ Employer Phone: _____

SECONDARY INSURANCE (Please present insurance card to receptionist)

Insurance: _____

Policyholder: _____ DOB: _____

Policyholder Address / Phone: _____

Employer: _____ Employer Phone: _____

AUTHORIZATION

I authorize the clinic to furnish relevant information to insurance carriers concerning this illness/accident and assign payment for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance and agree to pay copays at the time of service and all remaining balances within 30 days.

Responsible Party Signature: _____ Date: _____

PIENKOWSKI, M.D. CLINIC
ALLERGY ASTHMA IMMUNITY

MEDICAL HISTORY

Date: _____

MEDICATIONS

List medications or provide medication list to front desk (including prescriptions, over the counter medications, and supplements). Include dose, reason for taking, and prescribing doctor, if you are able.

Medication	Dose	Reason	Prescribing Doctor

SURGICAL HISTORY

List past surgeries (including office-based minor surgeries). Include name of surgeries, reason for surgery, and performing surgeon.

Surgery / Procedure	Year	Reason	Surgeon

PIENKOWSKI, M.D.
CLINIC
ALLERGY ASTHMA IMMUNITY

RELEVANT MEDICAL HISTORY

Allergic / Atopic

☐ Allergic Rhinitis	☐ Asthma	☐ Atopic Dermatitis	☐ Angioedema
☐ Chronic Urticaria	☐ Food Allergy	☐ Conjunctivitis	☐ Contact Dermatitis
☐ ABPA	☐ Eosinophilic Esophagitis	☐ Nasal Polyps	☐ Anaphylaxis
☐ Drug Allergy	☐ Insect Sting Allergy	☐ Chronic otitis	

Immunologic / Autoimmune

☐ Primary Immune Deficiency	☐ Secondary Immune Deficiency	☐ Autoimmune Thyroid Disease	☐ Dermatomyositis/ Polymyositis
☐ Sjogren Syndrome	☐ Scleroderma	☐ Vasculitis	☐ Rheumatoid Arthritis
☐ Lupus (SLE)	☐ IBD	☐ Celiac Disease	☐ Psoriasis
☐ Multiple Sclerosis	☐ Sarcoidosis	☐ Mast Cell Disorder	☐ Adrenal Insufficiency

Respiratory / ENT

☐ Chronic Sinusitis	☐ Recurrent Pneumonia	☐ Bronchiectasis	☐ COPD
☐ Obstructive Sleep Apnea	☐ Chronic Cough	☐ Vocal Cord Dysfunction	☐ Recurrent Otitis Media

Infectious

☐ Tuberculosis	☐ COVID-19	☐ Epstein-Barr Virus	☐ Cytomegalovirus
☐ HIV / AIDS	☐ Many Skin Infections	☐ Recurrent Strep	☐ Fungal Infections

Cardiometabolic / Systemic

☐ Diabetes Mellitus	☐ Hypertension	☐ Hyperlipidemia	☐ Coronary Artery Ds
☐ Heart Failure	☐ Chronic Kidney Disease	☐ Obesity	☐ Metabolic Syndrome
☐ PCOS	☐ Fibromyalgia	☐ Chronic Fatigue	☐ Leukemia/Lymphoma

Other(s): _____

PRIMARY CARE PHYSICIAN / PHARMACY

Physician Name: _____

Group / Business Name: _____

Physician Address: _____

Physician Phone: _____

Physician Fax: _____

Pharmacy Name: _____

Pharmacy Address: _____

PIENKOWSKI, M.D.
CLINIC
ALLERGY ASTHMA IMMUNITY

LIVING CONDITIONS

Your home is: ☐ New ☐ Old ☐ Apartment ☐ Trailer ☐ Separate Home

How is your home heated? ☐ Central ☐ Wood burning stove ☐ Radiator ☐ Other

Air Conditioning at Home: ☐ Central ☐ Window At Work: ☐ Central ☐ Window

Is there a cellar in your home? ☐ No ☐ Yes

If yes, is the cellar damp or moldy? ☐ No ☐ Yes

Air filter / purifier at home? ☐ No ☐ Yes

Recently been bit by a tick? ☐ No ☐ Yes

Any insects in your home? ☐ Ladybugs ☐ Stinkbugs ☐ Cockroaches ☐ Carpet Beetle

Any pets in your home? ☐ No ☐ Dog ☐ Cat Other: _____

RECREATIONAL DRUG USE HISTORY

Do you smoke regularly? ☐ No ☐ Yes

Do you drink alcohol daily? ☐ No ☐ Yes

Did you ever smoke regularly? ☐ No ☐ Yes

If yes, do you drink over 2 drinks? ☐ No ☐ Yes

Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Vape

If no, do you ever drink more than 4 drinks in a day? ☐ No ☐ Yes

Use other nicotine products? ☐ No ☐ Yes

Do you smoke marijuana daily? ☐ No ☐ Yes

ALLERGY MEDICATIONS

Please list allergy medications (prescription and over-the-counter) you use daily, seasonally, or as needed:

_____

_____

_____

_____

_____

_____

PIENKOWSKI, M.D.
CLINIC
ALLERGY ASTHMA IMMUNITY

FAMILY HISTORY

Name: _____ DOB:_____

Problem	Mother	Father	Brother	Sister	M. Grandmother	M. Grandfather	P. Grandmother	P. Grandfather	Son	Daughter
Alcohol / Drug Abuse										
Allergies										
Arthritis										
Asthma										
Autoimmune disorder										
Bleeding / Blood Disorder										
Cancer										
COPD										
Depression										
Diabetes										
Gastrointestinal Problems										
Genetic Diseases										
Genitourinary Problems										
Headaches										
Heart Problems										
High Cholesterol										
Hypertension										
Kidney Disease										
Mental Illness										
Musculoskeletal Disorders										
Nervous System Disorder										
Obesity										
Osteoporosis										
Sickle Cell Anemia										
Stroke										
Thyroid Disease										
Tuberculosis										
Eye Problems										
Immunodeficiency										

PIENKOWSKI, M.D.
CLINIC
ALLERGY ASTHMA IMMUNITY

REVIEW OF SYSTEMS

Patient Name: _____ DOB _____

Please check all symptoms you have experienced in the past 6 months:

1. CONSTITUTIONAL SYMPTOMS
☐ Fever
☐ Unexplained weight loss
☐ Fatigue/malaise
☐ Night sweats
☐ Generalized weakness
☐ Poor wound healing

2. NASAL/SINUS SYMPTOMS
☐ Nasal congestion
☐ Runny nose/rhinorrhea
☐ Sneezing
☐ Nasal itching
☐ Postnasal drainage
☐ Loss of smell
☐ Facial pain/pressure
☐ Seasonal pattern

3. OCULAR SYMPTOMS
☐ Eye itching
☐ Eye redness
☐ Tearing/watery eyes
☐ Eyelid swelling
☐ Eye discharge

4. RESPIRATORY SYMPTOMS
☐ Wheezing
☐ Shortness of breath
☐ Chest tightness
☐ Chronic cough
☐ Cough with exercise
☐ Nighttime cough

5. CARDIAC SYMPTOMS
☐ Chest pain
☐ Rapid heartbeat
☐ Palpitations
☐ Irregular heartbeat
☐ Dizziness / lightheadedness
☐ Syncope (fainting)
☐ Low blood pressure episodes

6. SKIN SYMPTOMS
☐ Hives/urticaria
☐ Itching (pruritus)
☐ Eczema/atopic dermatitis
☐ Flushing (face, neck, chest)
☐ Angioedema (swelling of lips, tongue, face)
☐ Rashes from metals
☐ Rashes from other contacts
☐ Skin infections (frequent)

7. NEUROLOGIC SYMPTOMS
☐ Headaches (frequent)
☐ Brain fog
☐ Memory problems
☐ Difficulty concentrating
☐ Numbness/tingling
☐ Muscle weakness
☐ Neuropathic pain (burning, shooting pain)
☐ Balance problems

8. PSYCHIATRIC SYMPTOMS
☐ Anxiety
☐ Depression
☐ Mood swings
☐ Irritability
☐ Sleep disturbances
☐ Panic attacks

9. ORAL SYMPTOMS
☐ Lip swelling
☐ Tongue swelling
☐ Mouth/throat itching
☐ Tingling of lips or mouth
☐ Recurrent mouth ulcers

10. GASTROINTESTINAL SYMPTOMS
☐ Nausea
☐ Vomiting
☐ Abdominal pain/cramping
☐ Diarrhea
☐ Reflux/heartburn
☐ Blood in stool
☐ Difficulty swallowing
☐ Bloating
☐ Constipation

11. MUSCULOSKELETAL SYMPTOMS
☐ Joint pain/swelling
☐ Joint stiffness (morning)
☐ Muscle pain/myalgias
☐ Bone pain
☐ Muscle atrophy/weakness

12. AUTOIMMUNE SYMPTOMS
☐ Dry eyes/dry mouth
☐ Hair loss
☐ Sun sensitivity
☐ Oral or nasal ulcers
☐ Recurrent fevers
☐ Swollen lymph nodes
☐ Fingers turn white & blue

13. ANAPHYLAXIS HISTORY
☐ History of severe allergic reaction
☐ Use of epinephrine auto-injector
☐ Emergency room visit for allergic reaction
☐ Sense of "impending doom" during reaction
☐ Loss of consciousness
☐ Throat swelling/difficulty breathing

14. FOOD ALLERGY SYMPTOMS
☐ Symptoms after eating specific foods
☐ Foods consistently cause symptoms
☐ Exercise-related food reactions

15. RECURRENT INFECTIONS
☐ Frequent sinus infections
☐ Frequent ear infections
☐ Frequent pneumonia
☐ Frequent skin infections
☐ Chronic diarrhea/GI infections
☐ Infections requiring IV antibiotics
☐ Unusual infections

PIENKOWSKI, M.D. CLINIC
ALLERGY ASTHMA IMMUNITY

HIPAA NOTICE OF PRIVACY

PRACTICES ACKNOWLEDGMENT

I acknowledge that I have received the HIPAA Notice of Privacy Practices (the "Notice") from Allergic Diseases, Asthma and Immunology Clinic, P.C. d/b/a Pienkowski MD Clinic (the "Clinic") and that I have been provided an opportunity to review it.

I understand that:

- I have certain rights to privacy regarding my protected health information.
- The Clinic may use my health information for treatment, payment, and health care operations.
- The Notice explains how my protected health information may be used and shared.
- I have rights regarding my protected health information as described in the Notice.
- The Clinic may change the Notice and I can obtain a current copy upon request.

Patient Acknowledgement

Name: _____

Date of Birth: _____

Signature: _____

Date: _____

Relationship to Patient: _____

Good Faith Effort to Obtain Acknowledgment (if patient unable to sign)
(For Office Use Only)

Name of Patient: _____

Date of Birth: _____

Reason Signature Could Not Be Obtained:

_____

_____

_____

Staff Name: _____

Staff Signature: _____

PIENKOWSKI, M.D. CLINIC
ALLERGY ASTHMA IMMUNITY

RELEASE OF PROTECTED HEALTH

INFORMATION AUTHORIZATION

Patient Name (Print): _____

Date: _____

I authorize the physicians and staff of Allergic Diseases, Asthma & Immunology Clinic, P.C. d/b/a Pienkowski MD Clinic to discuss my protected health information with the individuals listed below.

Please list family members or friends who may have access to your health information because they are involved in your care or payment for your healthcare.

Name (Print)	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature: _____

Date: _____

PIENKOWSKI, M.D.
CLINIC
ALLERGY ASTHMA IMMUNITY

PAYMENT POLICY

Our primary purpose is to provide you with the best medical care available. We appreciate the confidence you have shown in our clinic by choosing us for your healthcare needs.

We make every effort to keep your medical costs down. You can assist in this effort by paying at the time of your visit. Collecting payment at the time of service helps reduce administrative costs that are unrelated to providing medical care.

Important: All copays are due at the time of your visit. We accept cash, check, debit cards, and credit cards.

We file insurance claims as a courtesy to our patients. However, your insurance policy is a contract between you and your insurance company. You are ultimately responsible for payment of your account.

Please initial the statement below:

I will pay my copay and any additional amounts due at the time of each visit.

Initials: _____

This policy does not apply to patients whose insurance plans require the clinic to file claims as part of our contractual agreement as an in-network provider.

We file Medicare claims as required by law. Patients are responsible for any applicable copayments, coinsurance, or deductibles according to their insurance plan.

If you are unable to meet your financial obligations, financing may be available through CareCredit. Accounts that remain unpaid for 90 days may be referred to a collections agency.

Patient / Guardian Acknowledgment

Name: _____

Date: _____

Signature: _____

PIENKOWSKI, M.D. CLINIC
ALLERGY ASTHMA IMMUNITY

PATIENT CANCELLATION POLICY

We strive to provide excellent patient care. To ensure that all patients have access to timely appointments, we have established the following cancellation policy.

Patients are expected to attend their scheduled appointments. When appointments are missed without advance notice, that time cannot be offered to another patient who may need care.

If you need to cancel an appointment, please provide at least 24 hours notice. This allows the clinic to offer the appointment time to another patient.

If you must cancel after the office is closed, including weekends or holidays, please call the office and leave a voicemail message.

Appointment cancellations should otherwise be made during normal business hours.

Missed Appointment Fee: If an appointment is missed without at least 24 hours notice, a fee of $20.00 may be assessed. This fee is the responsibility of the patient and will not be billed to your insurance company.

If an unavoidable emergency occurs, please notify the clinic as soon as possible. We understand that emergencies happen and will review these situations accordingly.

The clinic utilizes an automated appointment reminder system to help patients remember upcoming visits. Please provide a contact number where you regularly check messages.

We appreciate your cooperation in helping us provide the best possible care to all of our patients.

Patient / Guardian Acknowledgment

Name (Print): _____

Patient Signature: _____

Date: _____

PIENKOWSKI, M.D. CLINIC
ALLERGY ASTHMA IMMUNITY

Parental Release Form

I authorize Allergic Diseases, Asthma and Immunology Clinic, P.C. d/b/a Pienkowski MD Clinic (the 'Clinic') to administer medical treatment to my child:

Child Name: _____

Treatment may include, but is not limited to, allergy injections. I understand that I must be present for any scheduled appointments with a physician or nurse practitioner.

The individuals listed below are authorized to bring my child to the clinic or obtain health care for my child in my absence. Anyone not listed will not be allowed to obtain health information or bring my child for treatment.

Name (Print): _____ Relationship: _____

Name (Print): _____ Relationship: _____

Name (Print): _____ Relationship: _____

Signature of Parent / Legal Guardian: _____

Date: _____