PATIENT INFORMATION

Allergy, Asthma AND IMMUNOLOGY
Advanced, personalized care for effective relief

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

PATIENT INFORMATION:

Patient's Name _____ SS# _____

Birth date _____ Age _____ ☐Male ☐Female ☐Other_____ Phone # _____

Mailing Address _____ City/State _____ Zip _____

Check appropriate box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

E Mail address: _____ Pharmacy/Phone # _____

Employer_____ Occupation_____ Work # _____

Whom may we thank for referring you? _____

Responsible Party:

Name of person responsible for this account _____ Relationship to patient: _____

Driver's License #: _____ SS# _____ Date of Birth _____

Address _____ City/State _____ Zip _____ Phone# _____

IF PATIENT IS A MINOR OR STUDENT:

Mother's Name _____ Birth date _____ SS# _____

Address _____ City/State _____ Zip _____ Phone# _____

Father's Name _____ Birth date _____ SS# _____

Address _____ City/State _____ Zip _____ Phone# _____

INSURANCE INFORMATION:

Primary Ins Company _____ ID#_____ Group # _____

Policy Holder's Name_____ Employer_____ DOB _____

Secondary Ins Company _____ ID#_____ Group # _____

Policy Holder's Name_____ Employer_____ DOB _____

EMERGENCY CONTACT (Person out of the Home)

Name _____ Phone#_____ Relationship _____

CONSENT AND AUTHORIZATION:

I hereby give my consent and authorization for Allergy, Asthma and Immunology, PSC to use or disclose my personal health information as they see fit. I understand I have the right to review the provider's privacy notice, to request restrictions and to revoke this consent at any time. This consent and authorization is valid for Allergy, Asthma and Immunology, PSC. I also authorize and request that payment under my insurance programs be made directly to the above provider for any services furnished to me. I understand even though I have insurance, I am responsible for payment.

Signed _____ Date _____

Allergy, Asthma
AND IMMUNOLOGY
Advanced, personalized care for effective relief

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.

- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

- The practice may condition receipt of treatment upon execution of this consent.

PRIVACY PRACTICES & PATIENT ACKNOWLEGEMENT

May we phone, email, or send a text to you to confirm appointments? ☐YES ☐NO

Preferred phone number: _____
☐Cell or ☐Home

Alternate phone number: _____
☐Cell or ☐ Home

Email:(please print)_____

May we leave a detailed message on your answering machine at home or on your cell phone? ☐ YES ☐NO

May we discuss your medical condition with any member of your family? ☐YES ☐ NO

If YES, please name the members allowed (please print)

Name/ Date of Birth :

_____
_____
_____
_____

Patient's Name: _____

Patient's Date of Birth: _____

This consent was signed by:

_____
(PRINT NAME PLEASE) / relationship if minor

Signature: _____

Date: _____

Witness: _____

Date: _____

Patient History

Patient Name: _____ D.O.B. _____ Today's Date: _____

Reason for seeing the doctor : _____

_____

Current medications: _____

_____

_____

Personal History: (age at onset)

Asthma _____ Ear infection(s)_____ Colic _____

Bronchitis _____ Throat infections _____ Eczema _____

Sinus problems _____ Hives _____ Hay Fever _____

Diarrhea _____ Rashes _____ Coughing _____

Nausea _____ Headaches _____ Sneezing _____

Stomach problems _____ Other _____

Worst Season: ☐Winter ☐Spring ☐Summer ☐Fall ☐All Year

Circle if worse: ☐After eating – ☐Exertion – ☐Indoor –☐Outdoor – ☐Work –☐Home – ☐School – ☐Morning – ☐Day – ☐Night – ☐Changes in weather – ☐Air conditioning

Aggravating Factors : ☐Dust – ☐Dog – ☐Cat – ☐Feathers –☐Hay – ☐Barn – ☐Cattle – ☐Horses –☐Fur – ☐Wool – ☐Odors – ☐Tobacco – ☐Colds – ☐Cosmetics – ☐Smoke – ☐Leaves – ☐Mowing

Pollens _____ Flowers _____ Plants _____ Foods _____

Allergy to Insects: ☐Mosquito – ☐Bee – ☐Wasp – ☐Other:_____

Allergy to medicines:☐Aspirin – ☐Penicillin – ☐Sulfas – ☐Mycins – ☐Tetanus – ☐Other:_____

Serious illnesses: _____

Date of last chest X-ray: _____

Previous surgery: ☐Tonsils and ☐adenoids Date:_____ Physician: _____

☐Nose – ☐Polyps – ☐Sinuses – ☐Ear tubes Date:_____ Physician: _____

Other: _____

Previous allergy testing date: _____ Physician:_____

Treatment: _____ How long: _____

Family History: Does any member of the family have: ☐Allergies–☐Asthma–☐Hay Fever–☐Rash-☐Hives ☐Father – ☐Mother – ☐Brother – ☐Sister – ☐Uncle – ☐Aunt – ☐Grandparent

Living Conditions:

Type of setting : ☐City ☐Country Basement: ☐Damp ☐Dry Bathroom: ☐Bathtub ☐Shower

Carpet House : ☐Brick ☐Frame Bedrooms: Pillows – Feather – Dacron – Foam – Plastic covered

☐Trailer ☐Apartment Mattress – ☐Innerspring – ☐Foam – ☐Cotton – ☐Feather

Type of heating : ☐Gas ☐Electric Floors – ☐Carpet – ☐Linoleum – ☐Tile –☐Hardwood

☐Coal ☐Wood ☐Other: _____ Windows - ☐Curtains – ☐Drapes – ☐Blinds

Air conditioning : ☐None- ☐Central -☐Window Any stuffed toys: _____

Pets: ☐Cat ☐Dog ☐Bird ☐Indoor or ☐Outdoor Animals : ☐Horse ☐Cattle ☐Rabbits ☐Other: _

Any exposure to cigarette or pipe smoke? ☐YES ☐NO

REVIEW OF SYSTEMS

Patient Name: _____ DOB: _____ Date: _____

CONSTITUTIONAL SYSTEMS

Good Health Lately..... ☐NO ☐YES
Recent Weight Change..... ☐NO ☐YES
Fever ..... ☐NO ☐YES
Fatigue ..... ☐NO ☐YES

EYES

Eye Disease or Injury ..... ☐NO ☐YES
Wear Glasses/Contact Lenses..... ☐NO ☐YES
Blurred Vision or Double Vision..... ☐NO ☐YES
Glaucoma ..... ☐NO ☐YES

EARS/NOSE/MOUTH/THROAT

Hearing Loss or Ringing ..... ☐NO ☐YES
Earaches or Drainage ..... ☐NO ☐YES
Chronic Sinus Problem or Rhinitis..... ☐NO ☐YES
Nose Bleeds ..... ☐NO ☐YES
Mouth Sores ..... ☐NO ☐YES
Bleeding Gums ..... ☐NO ☐YES
Bad Breath or Bad Taste ..... ☐NO ☐YES
Sore Throat or voice Change..... ☐NO ☐YES

CARDIOVASCULAR

Heart Trouble ..... ☐NO ☐YES
Chest Pain or Angina Pectoris ..... ☐NO ☐YES
Palpitation ..... ☐NO ☐YES
Shortness of Breath w/ Walking..... ☐NO ☐YES
Shortness of Breath while Lying Flat . ☐NO ☐YES
Swelling of Feet, Ankles or Hands .... ☐NO ☐YES

RESPIRATORY

Chronic or Frequent Coughs ..... ☐NO ☐YES
Spitting Up Blood ..... ☐NO ☐YES
Shortness of Breath ..... ☐NO ☐YES
Asthma or Wheezing..... ☐NO ☐YES

GASTROINTESTINAL

Nausea or Vomiting ..... ☐NO ☐YES
Frequent Diarrhea ..... ☐NO ☐YES
Painful Bowel Movements ..... ☐NO ☐YES
Constipation ..... ☐NO ☐YES
Rectal Bleeding or Blood in Stool..... ☐NO ☐YES
Abdominal Pain or Heartburn ..... ☐NO ☐YES

GENITOURINARY

Frequent Urination..... ☐NO ☐YES
Burning or Painful Urination ..... ☐NO ☐YES
Blood in Urine ..... ☐NO ☐YES

MUSCULOCKEKETAL

Joint Pain ..... ☐NO ☐YES
Joint Stiffness or Swelling ..... ☐NO ☐YES
Back Pain ..... ☐NO ☐YES

INTEGUMENTARY

Rash or Itching ..... ☐NO ☐YES
Varicose Veins ..... ☐NO ☐YES

NEUROLOGICAL

Frequent or Recurring Headaches ... ☐NO ☐ YES
Light Headed or Dizzy ..... ☐ NO ☐ YES
Convulsions or Seizures ..... ☐ NO ☐ YES

PSYCHIATRIC

Nervousness ..... ☐ NO ☐ YES
Depression ..... ☐ NO ☐YES
Insomnia ..... ☐ NO ☐YES

ENDOCRINE

Glandular or Hormone Problem ..... ☐NO ☐YES
Thyroid Disease ..... ☐NO ☐YES
Diabetes ..... ☐NO ☐YES