PATIENT INFORMATION FORM

PATIENT INFORMATION: (Please Circle) Minor Single Married Divorced Widowed

Last Name:______________________ First:______________________ M.I.____ Sex: M/F

Social Security #______________________ Date of Birth: ______________________ Age:__________

Address:______________________ City:______________________ State:_____ Zip:__________

Mailing Address: ______________________ City:______________________ State:_____ Zip:__________

Home # ______________________ Cell #______________________ Work #______________________

Name of Employer:______________________ Email Address:______________________

POLICY HOLDER INFORMATION: (If different from Patient) Single Married Divorced Widowed Separated

Last Name:______________________ First:______________________ M.I.____ Sex: M/F

Social Security #______________________ Date of Birth:______________ Relationship:______________

Address:______________________ City:______________________ State:______ Zip:__________

Home #:______________________ Cell #:______________________ Work #:______________________

Name of Employer:______________________ Email Address:______________________

SPOUSE INFORMATION: (If different from above)

Last Name:______________________ First:______________________ M.I.____

Social Security #:______________________ Date of Birth:______________ Phone #:______________

Address:______________________ City:______________________ State:_____ Zip:__________

GENERAL INFORMATION:

Family Physician Name:______________________ Phone:______________________

Who referred you to our office? (Doctor/Friend/Phonebook)______________________ Phone:______________

Incase of Emergency Notify:______________________ Phone#:______________ Relationship:__________

INSURANCE INFORMATION:

Primary Insurance Plan:______________________ Policy Holder's Name:______________________

ID#:______________________ Group#______________________ Phone:______________________

Secondary Insurance Plan:______________________ Policy Holder's Name:______________________

ID#:______________________ Group#:______________________ Phone:______________________

HIPAA INFORMATION: Instructions for the office when returning phone calls or reminding you about appointments.

I authorized the office to contact me at: [ ] Home [ ] Work [ ] Cell [ ] EMail and May leave messages at: [ ] Home [ ] Work [ ] Cell.

I authorize the office to leave detailed messages about insurance or payments: [ ] YES [ ] NO

If you prefer us to leave messages with a specific individual please list them below:

1 2 3.

PATIENT NAME: ______________________ **DATE:** ____________

SYMPTOMS

( ) Sneezing
( ) Blocked Nose
( ) Runny Nose
( ) Watery Eyes
( ) Headaches
( ) Post Nasal Drip
( ) Itching of the Nose
( ) Itching of the Eyes
( ) Itching of the Mouth/Throat
( ) Swelling of eyelids
( ) Swelling of the tongue/lips
( ) Swelling of the body
( ) Skin Rash or Eczema
( ) Shortness of Breath
( ) Chest Congestion
( ) Coughing
( ) Wheezing
( ) Hives
( ) Fatigue
( ) Nausea
( ) Diarrhea
( ) GERD
( ) Stomach Cramps

GENERAL INFORMATION

- What age did these symptoms first occur?

- How often do these symptoms occur and how long do they last?

- How severe are symptoms?

- Does any member in the household or a regular visitor smoke?

- Are you pregnant?

-- How many months?

MEDICAL HISTORY

Have you had:

( ) Hay Fever
( ) Croup
( ) Bronchitis
( ) Asthma
( ) Hives
( ) Skin Rashes
( ) Sensitivity to Foods
( ) Sensitivity to Drugs
( ) Sensitive to Insect Stings/Bites
( ) Skin/Allergy testing
( ) Allergy Shots
( ) Herbal Therapy or Acupuncture
( ) Others: ______________________

____

____

FAMILY HISTORY

Do any of these family members **have allergies**:

( ) Mom ( ) Dad
( ) Brother ( ) Sister
( ) Grandparents
( ) Other relatives

* List any other conditions that run in your family (diabetes, high blood pressure. etc.)

____

____

HOME ENVIRONMENT

Do you have:

( ) Central Air Condition
( ) Window A/C Units
( ) Gas Furnace
( ) Electric Furnace
( ) Basement
( ) Carpeting
( ) Allergy Relief Bedding
( ) Air Purifier
( ) Plants

* *Do you have a*:

( ) Cat ( ) Dog ( ) Bird
( ) Other ______________________

MEDICATIONS

List allergy prescriptions or allergy over the counter medications you are currently on:

____

____

____

____

____

List **all other** prescriptions or over the counter medications you are currently taking:
(if you have multiple please provide a copy for our records)

____

____

____

____

* Medications you have taken in the last year for **allergies or asthma** that is not on current list: ______________________

____

Other medications you took in the last year not on current list:

____

____

* *Medications you are allergic to*:

____

____

____

<u>SIGNATURE ON FILE</u>

Allergy & Clinical Immunology
Joseph Pflanzer, M.D.

1. I understand that I am financially responsible for all co-payments, deductibles, co-insurance or non-covered services.
2. I hereby authorize release of patient information to my insurance company(ies) and authorize my doctor to act as my agent in helping me obtain payment.
3. I will respond within **15 days** to any request for additional information or change made by my insurance company(ies) and accept full responsibility for payment of services if the information is not provided.
4. I authorize all medical payments, for services received in your office, sent directly to Joseph Pflanzer, M.D.
5. I understand that I must take role upon helping your office receive any referral from my Primary Care Physician.
6. I understand, all services received without proper authorization or referral from my PCP will be my responsibility.
7. ***Failure to keep my appointment without a minimum of 24 hour notice may subject to a $25 – $50 fee to my account.***
8. I understand that this authorization is valid up to 1 yr of the signed date, unless otherwise stated by me in writing.

Patient Name: ______________________________ D.O.B: ______________

Responsible Party: _________________________ Relationship: ____________

Signature: _________________________________ Date: ______________

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: ______________________________ Birthdate: ______________

Signature: ____________________________ Date: ______________

POSSIBLE RISK OF TESTING

Skin testing will be administered at this office with a medical physician or nurse practitioner present since occasional reactions me require immediate therapy. These reactions may consist of any or all of the following: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; feel faint; nausea and vomiting; hives; generalized itching; and on extremely rare occasions, shock.

PLEASE NOTE THAT THESE REACTIONS RARELY OCCUR BUT IN THE EVENT A REACTION WOULD OCCUR, THE STAFF IS FULLY TRAINED AND EMERGENCY EQUIPMENT IS AVAILABLE.

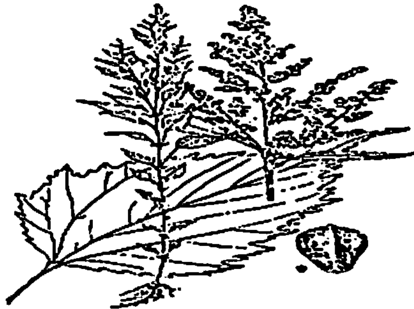
STATEMENT OF PATIENT OR ADULT PARENT/ GUARDIAN OR MINOR PATIENT

I have read the patient instruction and consent sheet and understand it. The opportunity has been provided for me to ask questions regarding the patient information sheet on allergy skin testing. The opportunity has been provided for me to ask question regarding the potential side effects of allergy skin testing and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions. Testing may take 1-2 hours

Patient Name (print): ______________________________ Date: ____________

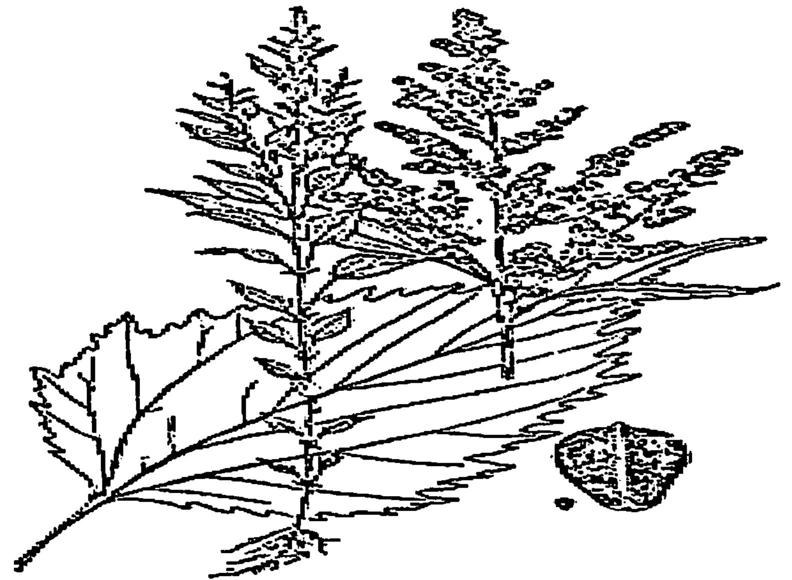
Patient/ Parent/ Guardian Signature: ______________________________ Date: ____________
{ } Adult Patient
{ } Parent/ Guardian Signature for Minor Patient

Physician: Joseph Pflanzer, M. D.
Physician (signature): ______________________________ Date: ____________



Joseph Pflanzer, M.D.
Bolton Boone Dr. Suite 101
DeSoto, TX 75115
www.pflanzermd.com

INFORMED CONSENT SHEET FOR ALLERGY SKIN TESTING ADULTS & CHILDREN



JOSEPH PFLANZER, M. D.
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INOFRMED CONSENT SHEET FOR ALLERGY SKIN TESTING ADULTS & CHILDREN

SKIN TEST

Skin test are a method of testing for allergies. A test consists of introducing small amounts of allergies into the skin and noting the development of a positive reaction (a swelling or flare in the surrounding area of redness). The results are read 15 to 20 minutes after application of allergen.

TESTING METHODS

Prick- Puncture Method: The skin is lightly scratched with a specially designed plastic applicator containing each allergen.

Intradermal Method: This method consists of injecting small amounts of an allergen into superficial layers of the skin.

Interpreting the clinical significance of skin tests requires skillful correlation of the test results with the patient's clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms.

You will be skin tested to important area airborne allergens and food testing if necessary. The skin testing generally takes 1 to 2 hours. Prick test will be performed on your back and intradermal test on your arm. If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy bump will appear on your skin within 15- 20 minutes. The tests will be read by the Physician or Nurse Practitioner. Patients may be given an antihistamine after testing to help control the itching or a topical product may be applied to the testing area. Any positive reactions will gradually disappear over a period of time. Rarely, local swelling at a test site will begin 4 to 8 hours after the skin test are applied. If this occurs, please notify the office for treatment instructions. These local reactions are not serious and will disappear over the next week or so.

After all skin testing is complete, you will meet with Dr. Joseph Pflanzer to discuss the tests results and determine a treatment plan.

TESTING GUIDELINES

MEDICATIONS TO STOP USING PRIOR TO TESTING:

1. No prescription or over- the- counter antihistamines should be used 3-5 full days prior to the scheduled skin testing. These include cold tablets, night time medications, sinus tablets, hay fever medications, oral treatments for itchy skin, etc. Some examples of these drugs include Clariten, Alavert, Benadryl, Astelin, Nasal Spray, Tavist, Dimetapp, Rondec, Rescon, Tylenol PM/Allergy/FLU, Thera Flu Severe Cold and many other.
2. Do NOT take the following for 5 days prior to testing: Zyrtec, Clarinex, Hydroxyzine or Atarax.

If you have any questions whether or not you are using an antihistamine, please ask the Nurse or Doctor. This is not a complete list of medications.

3. Medications such as over- the-coutner sleeping medicines (e.g., Nytol) and other prescribed drugs, such as Doxepin (Sinquan), and Imipramine (Tofranil PM) have antihistaminic activity and should be discontinued at least two weeks prior to receiving skin tests. Please make the Doctor and Nurse aware of the fact that you are taking these medications so that you may be advised as to how long prior to testing you should stop taking them.

YOU MAY CONTINUE:

1. You may continue using intranasal allergy sprays such as FLonase, Nasonex, Rhinocort, Aqua, Nasacort AQ, Nasarel, Saline, Afrin, or Veramyst.
2. You may continue all Asthma Medicationssuch as Advair, Pulmicort, Qvar, Combivent, Serevent, Disckus, Maxair, Provetil, Albuterol, Intal, Foradil, Spiriva, Singulair and Symbicort.
3. You may take over-the-counter decongestants such as Sudafed, Guaifenesin, Mucinex or Pain Relief medication such as Acetaminophen or Ibuprofen. (All of these must be free of antihistamines).
4. Most drugs do not interfere with skin testing but make certain that your physician and nurse know about every drug you are taking.
5. Fasting is NOT necessary.

PLEASE LET THE PHYSICIAN AND NURSE KNOW:

1. If you are taking any beta-blockers or antidepressants.
2. If you are pregnant.
3. If you have a fever or wheezing.
4. Any Medication you are taking (bring a list if necessary).

+ Please do not bring small children with you during your testing procedures unless they are accompanied by an adult.
+ Anyone 17 years old or younger must have a parent present during the entire procedure unless written consent is signed by the parent or legal guardian prior to testing.

Date:

(Please be sure to complete reverse)

Name:

Physicians

PCP:

Specialist MD:

Specialist MD:

Specialist MD:

Current Medical Diagnosis

- [ ] Heart attack
- [ ] High blood pressure
- [ ] Diabetes
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Stroke
- [ ] Cataracts
- [ ] Glaucoma
- [ ] Acid reflux disease
- [ ] Thyroid disease
- [ ] Auto-Immune disease
- [ ]

Surgical History (include year)

- [ ] Eye surgery
- [ ] Sinus surgery
- [ ] Ear surgery
- [ ] Removal of tonsils
- [ ] Removal of adenoids
- [ ] Removal of appendix
- [ ] Removal of gall bladder
- [ ] Other
- [ ]
- [ ]

General

- [ ] Fever
- [ ] Chills
- [ ] Weight Gain/Loss

Ears, Nose, and Throat

- [ ] Frequent ear infections
- [ ] Ringing in the ear
- [ ] Ear surgery
- [ ] Ear tubes
- [ ] Hearing loss
- [ ] Dizzy spells
- [ ] Snoring
- [ ] Sleep apnea
- [ ] Hoarseness
- [ ] Frequent sore throats
- [ ] Trouble swallowing

Cancer

- [ ] Type
- [ ]

For Women Only

- [ ] Are you currently pregnant
- [ ] Planning pregnancy in the future

Eyes

- [ ] Eye surgery
- [ ] Cataract
- [ ] Glaucoma
- [ ] Blurred vision
- [ ] Double vision
- [ ] Eye pain
- [ ] Infection of eyelashes or lids
- [ ]

Gastrointestinal

- [ ] Loss of Appetite
- [ ] Nausea/Vomiting
- [ ] Abdominal Pain
- [ ] Diarrhea
- [ ] Constipation
- Vomiting blood
- [ ] Blood in stool
- [ ] Diverticulitis
- [ ] Jaundice
- [ ] Hepatitis
- [ ] Heartburn
- [ ] GERD
- [ ] Ulcer
- [ ] Hiatal hernia
- [ ] Inflammatory Bowel Disease
- [ ] Irritable Bowel Syndromes (IBS)

Skin

- [ ] Hives
- [ ] Rash
- [ ] Eczema
- [ ] Skin cancer
- [ ] Psoriasis
- [ ]

Heart

- [ ] High blood pressure
- [ ] Chest pain
- [ ] Heart murmur
- [ ] Heart palpitations
- [ ] Irregular pulse
- [ ] Heart attack
- [ ] Pacemaker

Musculoskeletal

- [ ] Joint pain
- [ ] Joint stiffness
- [ ] Weakness of muscles/joints
- [ ] Muscle pain or cramps
- [ ] Rheumatoid arthritis
- [ ] Other arthritis syndromes
- [ ] Gout
- [ ] Sciatica
- [ ] Frequent neck pain
- [ ] Frequent back pain
- [ ] Osteoporosis

Endocrine

- [ ] Thyroid disease
- [ ] Diabetes
- [ ] Frequent thirst
- [ ] Heat intolerance
- [ ] Cold intolerance
- [ ] Easily fatigued

Lung & Chest

- [ ] COPD
- [ ] Pneumonia
- [ ] Pleurisy
- [ ] Chronic Bronchitis
- [ ]

Neurological

- [ ] Migraine
- [ ] Headaches
- [ ] Frequent dizzy spells
- [ ] Lightheaded
- [ ] Seizure disorder
- [ ] Tremor/hand shaking
- [ ] Stroke
- [ ] Numbness or Tingling
- [ ] Weakness

Hematologic

- [ ] Easily bruised or bleed
- [ ] Anemia
- [ ] Blood clots
- [ ] Blood transfusion
- [ ] Swollen glands

Psychiatric

- [ ] Anxiety
- [ ] Memory loss
- [ ] Moodiness

Smoking History

Do you smoke?

If yes - what do you smoke:

How many years:

How many packs per day:

Exposed to 2nd hand smoke?:

Alcohol Use

Do you drink alcohol?

If yes - what kind:

How many times a day?

Illicit Drug Use

Do you take any illegal drugs?

If yes - what kind:

How did you use?

Please list all medications including supplements and over the counter drugs you are taking. Be sure to indicate strength and how many times a day. If you have a list of medications, please provide it to a medical assistant and you can skip this list.

	Mother	Father	Brother (s)	Sister (s)	Maternal Grandparents	Paternal Grandparents	Son (s)	Daughters (s)
Allergies								
Asthma								
Eczema								
Sinus Problems								
Hives								
Food Allergies								
Thyroid Disease								
COPD								
Immunodeficiency								
Heart disease/heart attack								
Stroke								
Auto-immune Disease								
Cancer (indicate type)								

Environmental History

Animal Exposure

Do you have any pets?

Number of cats:

- [ ] Sleep indoors
- [ ] Sleep outdoors

Number of dogs:

- [ ] Sleep indoors
- [ ] Sleep outdoors

Number of birds:

Number of gerbils/guinea pigs:

Number of horses:

Other animals:

Are you exposed to any animals at work?

What kind?

Other:

Type of home:

Years in current home:

- [ ] House
- [ ] Apartment
- [ ] Mobile home
- [ ] Farm
- [ ]

Type of pillows:

Do you have pillow covers?

- [ ] Feather/Down
- [ ] Polyester
- [ ] Foam
- [ ]

Mattress:

Regarding your mattress:

How old?

Mattress covers?

Type of plants:

- [ ] Live
- [ ] Silk
- [ ] Don't have
- [ ]

Type of flooring:

- [ ] Carpeted
- [ ] Hardwood
- [ ] Tile
- [ ] Vinyl

Type of A/C:

- [ ] Central
- [ ] Window
- [ ] Cooler
- [ ]

Type of heating:

- [ ] Oil/gas
- [ ] Electric
- [ ] Coal
- [ ] Gas fireplace
- [ ] Wood fireplace
- [ ] Wood stove
- [ ]

Any of the following in your home?

- [ ] Ceiling fans
- [ ] Humidifier
- [ ] Air filter
- [ ] Stuffed animals
- [ ] Bookcases
- [ ]

Other

Are you sensitive to perfumes?

What kind?