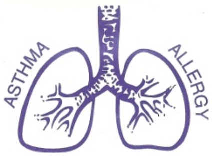
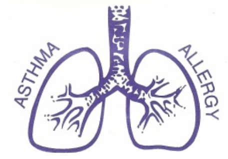


Asthma Allergy Care Center

PATEINT INFORMATION



Name____ Age _____ Birth date _________________ ☐M ☐F

Address ____________________________ City _________________ State _____ Zip ___________

Home Phone (___)_____________ Cell Phone (___)_____________ Email Address_________________________

Student Yes No Employer ____________________________ Work Phone (____)___________

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name _________________________ Spouse's Employer ________________

Spouse's Work Phone (____)_____________ Spouse's Work Address _______________________

Are any family members patients here? ☐ yes ☐ no If yes who? _____________________________

Emergency contact information: (Close relative not living with you) Name _________________________________

Address: (St., P.O. Box, Apt. No.)______________________City______________State___________Zip___________

Home Phone________________________________ Cell Phone _______________________________

REFERRING PHYSICIAN/ PCP INFORMATION: (please be sure to give us their telephone numbers)

Doctor who referred for consultation ____________________ Tel No.____________Location___________________

Patient's Primary Care Physician _____________________ Tel No. _________________ Location _________________

PERSON RESPONSIBLE FOR BILL

Name _______________________ Dr. Lic. No. _________________

Relationship to patient: Self/ Father/ Mother/ Spouse/ Other (explain) ________________________

Address (if different from Patient's) ____

Phone: Home _______________ Work _________________ Cell _______________ Email ____________________

IF PATIENT IS A MINOR:

Mother's Name _________________ Employer ________________ DOB ______________ Work Phone ______________

Father's Name __________________ Employer ________________ DOB ______________ Work Phone ______________

Legal Guardianship: ☐Parents ☐Mother Only ☐Father Only ☐Other _______________________

Health Insurance (You MUST bring your insurance cards with you.)

Company Name	Policyholder Name	Policy No.	Effective Dates
1st ______________________	______________________	__________________	___________________
2nd ______________________	______________________	___________________	___________________

****** We will bill only your primary insurance*******

Patient Name ________________________________ **Date of Birth** ________________________

Race: ________________ **Ethnicity** __________________ **Language Preference:** __________________

OTHER INFORMATION

Does your insurance require referral or pre-certification to see a specialist? ☐Yes ☐no ☐don't know

Is treatment of allergies covered by your Insurance? ☐Yes ☐no ☐don't know

How much is your deductible? $__________. Is it ☐yearly? ☐Half yearly? Is it ☐per person ☐whole family?

Have you met your deductible for this year? ☐Yes ☐no In which month does your deductible restart? __________

How did you learn about us? ____

Who should we sent your evaluation report to? ____

PAYMENT & BILLING POLICIES

For Medicare, Medicaid and other insurance programs that list us as preferred provider, you are responsible for the deductible and copayments, **which must be paid at the time of visit.** We will submit and follow up the claims with Primary insurance only.

For all other insurance policies, the deductible and copayment **must be paid at the time of visit**. We will submit your insurance claim if you wish, but you must follow up with your insurance company. In all cases you are responsible for whole or any part of the bill not covered by insurance.

If you are unable to pay as above at time of visit, **please call in advance or see the receptionist before you see the doctor** to make alternate arrangements. **We accept Visa/ MC** .

CONSENTS:

With respect to the patient described on this form, for services performed by any medical provider at or on behalf of Asthma Allergy Care Center, I agree and give my consent as follows:

1. To conduct medical tests and give medical treatment as per the provider's best judgment.
2. Use of this form as authority to submit bills and receive payments from my Health Insurance Companies.
3. To release any or all information and to send medical reports to my Health Insurance Companies, the referring doctor, the primary doctor and any other doctor treating the patient.
4. To contact me by telephone for appointment reminders and call backs.
5. To act as my agent in obtaining payment from my Insurance Companies.
6. Use of a copy of this authorization in place of the original.
7. I understand I am responsible for my bill and will abide by the above Payment & Billing Policies.

I confirm that all information given on these papers is true to the best of my knowledge and that I have legal authority to give these consents on behalf of myself / or above named patient (Patient Name)_____________________________

Signature of responsible person ____

Witness ____ Date _______________________

Patient Name ____________________ **Date of Birth** ____________________

For what illnesses are you now seeking treatment?_______________________

Circle Symptoms:

NOSE:	Itching	Running	Sneezing	Stuffiness	Nosebleeds
EYES:	Itching	Watering	Swelling	Redness	Dark Circles
EARS:	Itching	Blocking	Infections	Fluid in Ears	Hearing Loss
THROAT:	Itching	Voice Loss	Infections	Hoarseness	Post-Nasal Drip
CHEST:	Coughing	Wheezing	Infections	Shortness of Breath	Pains
	Tightness	Extra Mucus	Smothering	Green/ Yellow Sputum	Blood in sputum
HEADACHE:	Sinus	Migraine	Tension	Facial Pain	Other
SKIN:	Hives	Eczema	Swelling	General Itching	Other
ABDOMEN:	Nausea	Cramps	Indigestion	Diarrhea	Constipation
GENERAL:	Fatigue	Feel sick	Infections	Weight/ Appetite Loss	

Which of the above are the most important to you?

Which of the above are currently bothering you? And for how long?

When did these problems occur for the first time in your life?

Are your symptoms: ☐ Constant? ☐ In attacks? ☐ Seasonal? ☐ Recently getting worse?

Are you worse in: Jan. Feb. March April May June July Aug. Sept. Oct. Nov. Dec.

If attacks: How often do you have them?

How long does each last? When did you have the last one?

Do you have some trouble all year round? ☐ Yes ☐ no

Which is your worst season? ☐ Spring ☐ Summer ☐ Fall ☐ winter ☐ All year around

If seasonal or in attacks, are you completely clear of symptoms between spells? ☐ Yes ☐ No

How many chest "colds" do you average per year?

Do you cough, wheeze, feel tight in the chest or short of breath after exercise? ☐ Yes ☐ No

Do you cough, smother or wheeze at night? ☐ Yes ☐ No If so how many nights a week?

Are there any foods you cannot eat for any reason other than taste? ☐ Yes ☐ No

If yes which foods and why?

Have you had any unusual or severe reactions to insect stings? ☐ Yes ☐ No

Are there any medications you cannot tolerate? ☐ Yes ☐ No If yes, Which and Why?

Patient Name ____________________ **Date of Birth** ____________________

Circle any of the following which cause or increase your symptoms:

House dust	Outdoors	Exertion	Food Odors	Temperature Change
Grass	Air Conditioners	Excitement	Flowers	Aspirin
Weeds	Cosmetics, Perfumes	Fatigue	Insect Stings	Menstrual Periods
Trees	Paints, Varnishes	Tension	Infection	Cigarette Smoke
Hay/ Grain	Industrial Fumes	Worry	Cold Air	
Animals	Insecticides	Laughing	Dampness, Rain	
Feathers	Soaps, Detergents	Infections	Weather Change	

Do you smoke? ☐ yes ☐ no If yes number of packs per day? _______ How many years? ____________

If you don't smoke, are there smokers in the house? ☐ Yes ☐ No

What treatment have you tried for this illness? What helped the most?

Current medications: For asthma and allergies: For other illnesses:

________________________________ ___________________________________

________________________________ ___________________________________

________________________________ ___________________________________

Do you use nose spray? ☐ Yes ☐ No If so, what kind?

Have you ever taken oral steroids (Prednisone, Medrol, etc.)? ☐ Yes ☐ No

When was the last time you had a chest X-ray?___________ Sinus X-ray?____________ TB Test? ________

Have you had allergy tests before? ☐ Yes ☐ No When?__________ By whom?______________

What were the main positive reactions?

Did you receive "injection" or hypo sensitization treatment? ☐ Yes ☐ No Did it help? ☐ Yes ☐ No

ENVIRONMENTAL HISTORY

Do you have pets or other animals around the house? ☐ Yes ☐ No

What kind?__________________________ In or out of the house? __________________________

Patient Name ____________________ **Date of Birth ____________________**

How many beds in patient bedroom? ____ Are there feather pillows in the house? ☐ Yes ☐ No

Plastic covers on mattress and pillows? ☐ Yes ☐ No

Mattresses are : ☐ Innerspring ☐ Waterbed ☐ Cotton ☐ Polyfoam ☐ Other

Carpeting in bedroom? _______ Rug pad? ____________ Drapes? ________________

Upholstered furniture? __________ Stuffed Animals? ___________ Type of Heating System? ______________

Air Conditioning? ___________________ Electronic Filter? _________________

Is the area around your house damp or moldy? ☐ Yes ☐ No

Is there any mold or mildew growth in your house? ☐ Yes ☐ No

Is there anything else around the house you suspect of causing your symptoms? ☐ Yes ☐ No

Are there any special dusts or fumes where you work? ☐ Yes ☐ No

CURRENT OR PAST ILLNESSES: Has the patient had any of the following? Please circle the applicable.

High Blood Pressure	Diabetes	Asthma	Hives	Tonsillectomy
Heart Disease	Tuberculosis	Bronchitis	Welts	Adenoidectomy
Heart Attack	Chicken Pox	Pneumonia	Eczema	Sinus Irrigation
Peptic Ulcer	Liver Disease	Hay Fever	Dermatitis	Tubes in Ears
Hiatus Hernia	Kidney Disease	Nasal Polyps	Poison Ivy	Nasal Surgery
Gastric Reflux	Leg Vein Thrombosis	Sinusitis	Ear Infection	Any major surgery

Any other Illnesses: Describe ____

Any hospitalizations? ☐ Yes ☐ No When, Where, Why? (please list)

If applicable, are you pregnant? ☐ Yes ☐ No Birth Control? ☐ Yes ☐ No

Are you up to date on your immunizations? ☐ Yes ☐ No

Have you had a pneumonia vaccine? ☐ Yes ☐ No

Did you get an annual Flu vaccine? ☐ Yes ☐ No

Have any BLOOD RELATIVES OF THE PATIENT had any of the following illnesses. Circle.

Bronchial Asthma	Hives	Migraine	Other Allergies	Emphysema
Hay fever	Sinus	Eczema	Nasal Polyps	Bronchitis

You must SAVE, PRINT, & BRING this form with you to appointment.