** 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Page 1**

**\*\*\*\* 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 deductable? $\_\_\_\_\_\_\_\_\_\_. Is it [ ] yearly? [ ] Half yearly? Is it [ ] per person [ ] whole family?

Have you met your deductable for this year? [ ] yes [ ] no In which month does your deductable 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 deductable 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Page 2**

**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

STOMACH: Nausea Cramps Indigestion Diarrhea Constipation

OTHER: Fatigue Fever 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, or feel tight in the chest 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 Which and Why?

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**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

Housedust 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 Nose Sprays

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Page 4**

**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. Page 5**