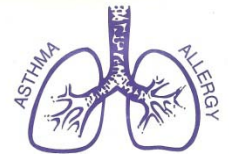


# Asthma Allergy Care Center

## PATEINT INFORMATION



Name \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_  M  F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ S.S.# \_\_\_\_\_

Student Yes No Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Marital Status  Single  Married  Widowed  Divorced  Seperated Email Address \_\_\_\_\_

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 \_\_\_\_\_

Name and address of closest relative not living with you :

Name \_\_\_\_\_ Address \_\_\_\_\_ Home 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 \_\_\_\_\_ S.S. No. \_\_\_\_\_ 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 \_\_\_\_\_

1<sup>st</sup> \_\_\_\_\_

2<sup>nd</sup> \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**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 Major Symptoms:

NOSE:	Itching	Running	Sneezing	Stuffiness	Nosebleeds
EYES:	Itching	Running	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 round

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?

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 |                    |

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?

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

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 |

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**ENVIRONMENTAL HISTORY**

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? \_\_\_\_\_

Do you have pets or other animals around the house? yes  no

What kind? \_\_\_\_\_ In or out of the house? \_\_\_\_\_

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

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