ALLERGY & ASTHMA CARE

Patient Registration Form

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Drug Allergies: YES NO (circle one)
If yes, please list: _____

_____

_____

DATE: ___/___/___ _____ UPDATE _____ UPDATE

_____ UPDATE _____ UPDATE

PATIENT INFORMATION

First Name	Middle Name	Last Name	Name Patient Goes By

Street Address	City	State	Zip Code	Home Phone	Cell Phone
				( )	( )

Date of Birth	Age	Sex	Social Security Number	Marital Status: (check one)
- -			- -	[ ] Single [ ] Married [ ] Divorced [ ] Widowed

Place of Employment	Occupation	Email Address	Work Phone
			( )

Spouse's Name	Place of Employment	Occupation	Work Phone
			( )

IF PATIENT IS A MINOR

Father's Full Name	Social Security Number	Date of Birth	Home Phone
	- -	- -	( )

Street Address	City	State	Zip Code	Place of Employment	Occupation	Work Phone
						( )

Mother's Full Name	Social Security Number	Date of Birth	Home Phone
	- -	- -	( )

Street Address	City	State	Zip Code	Place of Employment	Occupation	Work Phone
						( )

RESPONSIBLE PARTY INFORMATION

Full Name	Social Security Number	Date of Birth	Home Phone
	- -	- -	( )

Street Address	City	State	Zip Code	Place of Employment	Occupation	Work Phone
						( )

EMERGENCY CONTACT INFORMATION (Not living in same household)

Name	Address	Relationship	Phone Number
			( )

WERE YOU REFERRED BY FAMILY / FRIEND / DOCTOR? (please circle one)

Name	Street Address	City	State	Zip Code	Phone Number
					( )

PATIENT'S REGULAR PHYSICIAN

Name	Street Address	City	State	Zip Code	Phone Number
					( )

INSURANCE INFORMATION (*CARD WILL BE COPIED AT TIME OF VISIT*)

INSURANCE: PRIMARY	2ND	3RD

OFFICE USE ONLY

CHART #	DOCTOR	INITIALS

PLEASE READ AND SIGN REVERSE SIDE

RESPONSIBILITY, ASSIGNMENT OF BENEFITS & AUTHORIZATION STATEMENT

Patient Name_____ Chart Number_____

ASSUMPTION OF RESPONSIBILITY: The undersigned agrees, whether he/she signs as agent or as the patient, that in consideration of services rendered to the patient named above, he/she hereby obligates himself/herself, assumes financial responsibility and agrees to pay upon demand to Allergy & Asthma care, PLC any charges incurred by said patient. While the charges incurred may be paid in part by an insurance company or third party administrator, the undersigned assumes full responsibility for payment of any denied services, non-covered services, co-payments, co-insurance and/or deductibles. Should the account be referred to an attorney for collection, the undersigned agrees to pay reasonable attorney fees and/or collection expenses. There will be a $50 NSF charge incurred for any check returned by your bank.

REFERRALS / CO-PAYMENTS *J* DEDUCTIBLES: Many insurance companies require a referral from your primary care physician that must be obtained prior to seeing a specialist, and it is your responsibility to obtain any such required referral. If you are unable to obtain a referral in a timely manner, you may either sign a waiver stating that you will be responsible for your visit charges or you may reschedule your appointment for a later date. Our insurance department will file your claim for you; however, we do ask that you pay any co-payments and/or deductible amounts at the time of your visit. We will be happy to work with you to make payment arrangements if necessary.

ASSIGNMENT OF INSURANCE BENEFITS: As agent for the above referenced patient or as the patient, I hereby assign and direct payment of any benefits due to me and paid on my behalf, by CMS, any insurance company, or third party administrator, for any hospital insurance benefits, medical insurance benefits including major medical benefits, insurance sick benefits or accident/injury benefits., to Allergy & Asthma care, PLC for services rendered.

PRE-EXISTING CONDITION CLAUSE: Many insurance companies contain a clause that precludes coverage for "pre-existing conditions". The starting date of your disease, from the standpoint of the insurance company, will coincide with the time that your symptoms began. Therefore, you should take careful note of this when you fill out the medical form.
If your contract negates payment because it excludes your pre-existing condition, you will be held responsible for any charges incurred.

AUTHORIZATION TO RELEASE OR REQUEST INFORMATION: The undersigned hereby authorizes Allergy and Asthma care, PLC to release or request any sociological and medical information necessary to file insurance claims on behalf of the patient and authorizes the release of any information necessary to order laboratory and/or diagnostic testing.

I also authorize the release of any medical information, including any test/lab results and Rx information to the specific individual(s) listed below:

_____

_____

I HAVE READ AND UNDERSTAND ALL OF THE INFORMATION STATED ABOVE AND AGREE TO ACCEPT THESE CONDITIONS:

SIGNATURE_____ RELATIONSHIP _____ SELF
_____ PARENT/GUARDIAN
DATE_____ _____ OTHER

Date: _____ **Patient's Name:** _____

Referring physician: _____ **How old are you?** _____

1. Chief complaints (check your main symptoms, those that prompted your visit here):

HEAD OR NOSE SYMPTOMS		CHEST SYMPTOMS		SKIN SYMPTOMS		INSECT STINGS	
Sneezing	____	Cough	____	Hives	____	Hives-swelling	____
Nose blocking	____	Wheezing	____	Eczema	____	Shortness of breath	____
Runny nose	____	Shortness of breath	____	Itching	____	Wheeze	____
Postnasal drainage	____	Chest infections	____	Swellings	____	Dizziness	____
Sinus infections	____	Hoarseness or loss of voice	____			Passing out	____
Sore throat	____						
Ear blocking	____						
Headache	____						
Eye symptoms	____						

OTHER

Please explain in a few words: _____

_____

2. Approximately how many years have you suffered from the chief complaints of:

Head or nose symptoms (years) _____ Chest symptoms (years) _____ Skin symptoms (years) _____

Insect sting reactions (years) _____ Other (years) _____

Please note: This information may be important for your insurance coverage, especially in a patient who has recently obtained new insurance.

3. If you have respiratory symptoms, indicate their pattern:

	Head/Nose	Chest
Year round, no seasonal variation	_____	_____
Year round, worse seasonally	_____	_____
Seasonally only	_____	_____

If seasonal, list months _____

4. Do you note increased symptoms from any of the following:

ALLERGENS		IRRITANTS		WEATHER CHANGES		INGESTANTS	
Mowed grass	_____	Perfumes	_____	Windy days	_____	Alcoholic beverages	_____
Dead grass	_____	Soaps	_____	Cold fronts	_____	Drugs	_____
Dead leaves	_____	Detergents	_____	Temperature changes	_____	Foods	_____
Hay	_____	Smokes	_____	Damp weather	_____	Please list specific ingestants	_____
House dust	_____	Paint	_____				
Cats	_____	Hair spray	_____				
Dogs	_____	Outside dust	_____				
Feathers	_____						

_____

_____

(Please Turn Page Over)

Patient's Name: _____ **Date:** _____

5. **List medicines you use for relief of allergy symptoms:** _____

_____

6. **List any other drug you take regularly for any reason—include all over-the-counter drugs, creams, suppositories, eye drops, etc.:** _____

_____

7. **List any other drug you take occasionally for any reason:** _____

_____

8. **Are you allergic to any drug?** Yes _____ No _____ If so, please list drugs:

_____

9. **Do you use nose drops or sprays?** Yes _____ No _____

If so, how often? Occasionally _____ Regularly _____

Name(s) of spray(s) or drop(s): _____

10. **Have you taken hyposensitization shots ("allergy shots") previously?** Yes _____ No _____

11. **Are you still taking them?** Yes _____ No _____

If not, approximately how long did you take them? _____ **When did you quit?** _____

12. **Is there a history of any of the following in your family?**

	Yes	No	Relative: (e.g. Mother, Father, Sibling, etc.)
Asthma	☐	☐	_____
Hay fever	☐	☐	_____
Nasal polyps	☐	☐	_____
Eczema	☐	☐	_____
Hives	☐	☐	_____

13. **Do you have any pets at home?** Yes _____ No _____ If so, what kind? _____

Kept outside completely: _____ Outside some, inside some: _____ Inside most of time: _____

14. **How long has it been since you have had a chest x-ray?** _____

15. **Have you ever had a sinus x-ray?** Yes _____ No _____ If so, when? _____

16. **Do you smoke?** Yes _____ No _____ Packs per day: _____ How long? _____

17. **Have you ever smoked?** Yes _____ No _____ Packs per day _____ How long? _____

18. **Can you take aspirin?** Yes _____ No _____

(Please Turn Page Over)

Patient's Name: _____ **Date:** _____

19. **Have you ever been hospitalized?** Yes _____ No _____

If so, name cause of hospitalization. No need to list where you were hospitalized.

Cause of hospitalization:	Age When Hospitalized
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

Do you have any of the following:	Yes	No
20. Stomach ulcer (peptic ulcer)	_____	_____
21. Diabetes	_____	_____
22. High blood pressure	_____	_____
23. Glaucoma	_____	_____
24. Other problems with stomach or bowels	_____	_____
25. Other problems with heart	_____	_____
26. Problems with nervous system	_____	_____
27. Problems with urinary tract	_____	_____
28. Problems with blood	_____	_____
29. Problems with bones or joints	_____	_____

30. List any medical problems you have not noted above:

_____

_____

_____

_____

31. **At your work place are you exposed to allergens or irritants?** Yes _____ No _____

If yes, briefly explain: _____

_____

32. **Do you have hobbies or past times that expose you to allergens or irritants?** Yes _____ No _____

If yes, briefly explain: _____

_____

ALLERGY AND ASTHMA CARE

Nora Daher, M.D.
Tammy Heinly McCulley, M.D.
Mike S. Tankersley, M.D.
Gina Seaton APRN-BC,FNP
Alan DeJarnatt, M.D.
Brandon Hill, M.D.
George Treadwell, M.D.
Jerald M. Duncan, M.D.
Phil Lieberman, M.D.
Marcia Johnston, APRN-BC,FNP
Ingrid Cantrell, PA

FOR PATIENTS OF ALLERGY AND ASTHMA CARE

In order to familiarize you with our practice and orient you to our procedures we have prepared the following information. We hope that these suggestions are helpful to you in dealing with our office and physicians.

1. Our doctors are allergists. They specialize in allergic diseases. The care that they offer you will therefore be limited to the allergic disease for which you see them. Your general care should remain in the hands of your family practitioner, internist, or pediatrician. It is always desirable for our patients to have such a general doctor to contact for problems unrelated to their allergies. If you do not have such a general doctor we would be happy to recommend someone to you. We request all of our patients to have such a general physician.

2. We have several offices. Occasionally, when appointments are made, patients go to the wrong office. In order to save you the inconvenience involved of having to travel to another office, we ask you to make sure you know the office location where your appointment has been scheduled.

3. We are available to our patients on a 24-hour basis. We will of course take all of your calls and see you at any time if you are sick. We may be reached through our exchange and may be called directly at home after hours for medical emergencies. For problems which are not emergencies, such as prescription refills, we would greatly appreciate the calls coming to us during the regular work hours. Therefore your help in being able to anticipate your prescription refill needs so that they can be obtained during regular office hours is requested.

4. It would be very helpful to have your pharmacy number available whenever you call the office or the physician. This will save time and allow us to contact your pharmacy immediately. Please make sure the pharmacy whose number you give us is open at the time you call.

5. Of course we greatly appreciate your comments regarding our office procedures and personnel. Any time you have questions or problems we are delighted to answer them or help you with them. Please give us feedback on your experience with us.

Our telephone number for all offices is: 901-757-6100

Emergency calls after hours telephone number is: 901-541-5885

Important Patient Information (Rev June 2009)

Dear Patient: Please read the following information prior to coming in for your scheduled office visit

If your visit will include allergy/asthma testing, please allow 3 - 4 hours for your visit.

Discontinue *Antihistamines* for three (3) days prior to your appointment day. Do Not stop taking any of your other medications. Continue to take other medications prescribed for Asthma, COPD, Cardiac conditions, Diabetes, or any other health condition. *Only antihistamines need to be discontinued.*

The following is a list of just some of the products that contain antihistamines. This is not a complete list. Please check with your pharmacist if you are not sure if a medication that you are taking contains an antihistamine.

- ✓ Allegra (fexofenadine)
- ✓ Alavert (loratadine)
- ✓ Astelin (azelastine HCl)
- ✓ Atarax (hydroxyzine)
- ✓ Benadryl (diphenhydramine)
- ✓ Clarinex (desloratadine)
- ✓ Claritin (loratadine)
- ✓ Periactin (cyproheptadine HCl)
- ✓ Vistaril (hydroxyzine)
- ✓ Zyrtec (cetirizine)
- ✓ (Most over the counter Cold & Sinus medication and Allergy Relief medication contain Antihistamines)

As a courtesy to our patients with severe asthma and allergy conditions, we also request that patients refrain from wearing any perfumes or colognes on the day of their appointment.

Depending on your medical history, a sinus CT scan may be indicated. This test can be done here in our office for your convenience. Insurance coverage for this procedure does vary, therefore, you should contact your insurance company to find out your benefit coverage for this test when it is performed in a physician office setting. While we do obtain approval from your insurance company to do this test, we are unable to tell you if the charges will be applied to your deductible or paid under your office co-payment.

Please remember to bring your completed paperwork with you on the day of your appointment and all Rx medication bottles.

We look forward to your visit with us

To our patients: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Allergy & Asthma Care, P.L.C.
Notice of Privacy Practices
(Summary Notice – **Practice's Copy**)

PLEASE REVIEW THIS PAGE, SIGN BELOW, AND RETURN THIS COVER PAGE TO THE STAFF PERSON WHO GAVE IT TO YOU.

Under This Top Page, You Should Have Received A Longer Notice Document. If You Did Not, Please Request One From Our Staff Person Who Provided This Page To You.

Please keep the longer Notice document and take it home with you. YOU MAY REVIEW THE LONG-FORM NOTICE EITHER NOW OR LATER. In either case, let us know if you have any questions after reviewing it.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION:

Each time you visit a health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. The doctors and staff of our practice use and maintain this health information relating to the care you receive from us.

The longer Notice attached beneath this page contains information to help you understand what is in your medical record and how your health information is used. This helps you ensure the accuracy of such information, and lets you better understand who, what, when, where, and why others may have access to your health information.

Please sign below to acknowledge your receipt of the attached long-form Notice:

_____ _____

Patient name (*please print*) Signature or initials of patient or personal representative*

* If personal representative, please list relationship

_____

Relationship to patient

(For office use only)

Allergy & Asthma staff person's name:_____

Patient Med. Record #: _____ Date: _____

□ (Check if applicable) Patient did not acknowledge receipt of Notice (explain):_____

_____

Rev. 4/03

Form # 1020