New Patient Checklist

★ All new patients must bring their insurance card and valid ID
★ Please bring **ALL** medications to your visit, NOT a list. Bring a list of medical conditions
★ Bring copies of labs or medical records related to the visit. (**DO NOT FAX**) We are not able to access online medical records systems.
★ **IMMUNOLOGY** patients: bring copies of all recent labs and vaccination records
★ Our office sites vary in size and capacity. We recommend patients be accompanied by ***primary caregivers only***. (We are unable to accommodate more than two people per patient)
★ For the health and safety of our patients and our staff, please refrain from wearing any perfume, cologne or any scented products. **FOOD AND DRINK ARE NOT PERMITTED!**
★ It is pertinent that all patients check with their insurance regarding copays, referrals, coverage and deductibles you may be responsible for, DUE AT TIME OF VISIT
★ New patients should allow 2-3 hours for their initial visit, depending on the number and complexity of the medical issues to be evaluated
★ There is a **$35 NO SHOW FEE** for any cancellations made within 48 hours of a new patient visit.

ADVANCED ALLERGY & ASTHMA

Kumar Patel, M.D.

Patient Name (first, middle, last) _____

Age_____ Date of Birth_____

Address_____

Home Phone # _____ Cell Phone # _____

Email Address _____ Marital Status_____

Patients Occupation _____ Work Phone # _____

Employers Name _____

Emergency Contact (Name, number, relation)_____

Primary Care Physician (Name and Number)_____

Referring Physician (Name and Number)_____

Pharmacy (Name and Number)_____

FINANCIAL RESPONSIBILITY:

Name_____ Date Of Birth_____

Relationship_____

Address (If different from above)_____

Phone # (If different from above)_____

INSURANCE INFORMATION:

Name of Insurance Company_____

Policy Holders Name/Relationship_____ Date of Birth_____

Member ID Number _____ Group Number _____

Secondary Insurance_____

I consent to treatment necessary for the care of the above patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I understand that payment of copays incurred is due at the time of services. I further agree to pay all reasonable attorney fees and collection costs in the event of a default on my account. I further authorize and request that insurance payments be made directly to Advanced Allergy & Asthma, Dr Kumar Patel. I have read and fully understand the above, consent for treatment, financial responsibility, release of medical information and insurance authorization.

_____ _____

Signature of Patient/Parent/Guardian Date

Advanced Allergy & Asthma

Kumar Patel, M.D.

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. HIPAA, the Health Insurance Portability and Accountability Act, requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Advanced Allergy and Asthma requests that each patient sign this consent form which allows us to share protected health information with other physician offices and insurance companies.By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Members

Many of our patients allow us to share health information and results from tests and procedures with family members such as their spouse, parents and others. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patients consent. If you wish for your information to be released, please check **YES** below and specify which family member(s).

You have the right to revoke this consent in writing except where we have already made disclosures in alliance to your prior consent. **YES**_____ **NO**_____

Name of

individuals(s)_____

_____

Authorization to Leave Voicemail

YES_____ **NO**_____

Medication Authorization

I give Advanced Allergy and Asthma permission to obtain an active medication list through electronic prescribing of all medications taken by the patient.

YES_____ **NO**_____

Patient Name:_____

Patient/Guardian Signature_____ Date_____

Advanced Allergy and Asthma

Kumar Patel, M.D.

AUTHORIZATION TO BILL INSURANCE AND PATIENT RESPONSIBILITIES

You have been referred to this office due to a specific allergy problem (asthma, sinusitis, hay fever, hives, stinging insect allergy, eczema, food or drug allergies, etc.). Advanced Allergy and Asthma is a specialty practice, and we work in conjunction with your primary care or referring physician, to provide you with your necessary medical management.

An allergic investigation includes a detailed history, physical examination, skin tests, pulmonary testing, and a thorough discussion, with all results at the conclusion of the investigation. Any laboratory procedures, if deemed necessary, will be performed outside the office.

It is the responsibility of the patient to make arrangements for all authorizations (if required) once an appointment has been scheduled with Advanced Allergy and Asthma.

We will submit visit charges to your insurance company. **Any DEDUCTIBLE, CO-PAYMENT or NON COVERED service will be the responsibility of the patient.**

If after reviewing this information, there are additional questions, please do not hesitate to contact our office.

Patient Name_____

Patient/Guardian Signature_____ Date_____

NEW PATIENT QUESTIONNAIRE

Name:_____ Age:_____ DOB:_____ Date:_____

Reason you're being seen?_____ When did your symptoms first begin? _____
When, if so, did they get worse?_____

Are your symptoms: ☐seasonal * * ☐all year long ☐ all year long, with seasonal worsening * *
* * Circle the worst months: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

What makes your symptoms worse:

Irritants	**Weather**	**Medicine**	**Allergens**	**Location**	**Other**
☐ smoke ☐ air pollution fumes or car exhaust ☐strong odors or perfumes	☐ cold air ☐ rapid temperature change (e.g. going from cold outdoors to indoor heat)	☐ aspirin ☐ Non-steroidal anti-inflammatory agents (e.g. Motrin, Advil, Aleve)	☐ grass/tree/weeds ☐dust or vacuuming ☐ damp/musty area ☐animals __dog __cat __other	☐ outdoors ☐ indoors ☐ daycare ☐ home ☐ school ☐ work	_____ _____ _____ _____ _____ _____ _____

Social History

Occupation/Job/School :_____

Smoking status: **Second hand smoke exposure:** ☐ Yes ☐ No
☐ Current smoker # of yrs _____ Packs per day_____

Pets in the home: (circle) Dog Cat Rabbit Hamster Guinea Pig Other_____

Housing: ☐ House ☐ Apartment ☐ Urban ☐ Suburb ☐ Farm/Rural # of year at this residence_____

Heating: ☐ Gas ☐Electric ☐ Wood Burning ☐ Oil **A/C:** ☐ Central A/C ☐ Window A/C ☐ None
Humidifier: ☐ Room ☐ Central ☐ None

Bedding: Pillow: ☐ Feather/Down ☐ Synthetic **Comforter:** ☐ Feather/Down ☐ Synthetic

Flooring: Bedroom: ☐ Carpet ☐ Tile ☐ Wood **House:** ☐ Carpet ☐ Tile ☐ Wood

Hobbies/Sports:_____

Check any of the illnesses/medical conditions that you have had.

☐ Asthma ☐ Heart attack/angina ☐ Irritable bowel
☐ COPD ☐ Atopic Dermatitis/eczema ☐ Thyroid disease
☐ High blood pressure ☐ Headaches ☐ Heartburn/acid reflux
☐ Hay fever ☐ Arthritis ☐ Psoriasis
☐ Pneumonia ☐ Osteoporosis
☐ Anxiety ☐ Diabetes

(over)

List all surgeries/operations/hospitalizations: _____

_____

List all prescription and over-the-counter medications you are currently using (Name & Dosage):

1)_____ 4)_____ 7)_____

2)_____ 5)_____ 8)_____

3)_____ 6)_____ 9)_____

What medications have you tried for your allergy problems in the past? Has it been effective? _____

_____

Are you allergic to any medications? If so, list drug, type of reaction and when: _____

_____

Allergy Review of Symptoms - Check all that apply or are abnormal:

Headaches: ☐ Frontal ☐ Maxilla ☐ Temporal **Sinusitis:** Location_____ ☐ **Snoring** ☐ **Sleep Apnea**

Eyes: ☐ Redness ☐ Itch ☐ Tearing ☐ Puffiness

Ears: ☐ Freq-Infect ☐ Hearing Loss ☐ Pain ☐ Tubes (age)___ ☐ Pressure/congestion

Nose: ☐ Colds ☐ Itch ☐ Runny nose ☐ Bleeding ☐ Stuffiness ☐ Sneezing ☐ Post Nasal Drip ☐ Decreased Sense of Smell/Taste

Throat: ☐ Freq-Infect ☐ Clearing Freq ☐ Bad Breath ☐ Voice Change ☐ Sore Throat ☐ Hoarseness ☐ Swollen Glands ☐ Tonsils or Adenoids removed (age)_____

Chest: ☐ Asthma ☐ Chronic Cough ☐ Bronchitis/Pneumonia ☐ Shortness of Breath ☐ Chest Tightness ☐ Wheezing

Skin: ☐ Eczema ☐ Urticaria (hives) ☐ Insect bites ☐ Contact Dermatitis ☐ Atopic Dermatitis (eczema) ☐ Angioedema (swelling)

GI: ☐ Nausea/Vomiting ☐ Bowel Change ☐ Appetite Change ☐ Lactose Intolerance ☐ Jaundice

GU: ☐ Infection ☐ Blood in Urine ☐ Incontinence ☐ Burning Urination

General: ☐ Weight loss ☐ Emotional Problems ☐ Sleep Pattern ☐ Missed School/Work ☐ Muscle Aches ☐ Night Sweats

Number of Courses of Antibiotics in Past 12 Months: _____

Do you know of any blood relatives who have or had the following? Please check and give relationship.

☐ Asthma _____

☐ Allergic Rhinitis/Hay Fever_____

☐ Food Allergies_____

☐ Atopic Dermatitis/Eczema_____

☐ Thyroid Disease_____

☐ Angioedema (Hereditary Angioedema)_____

☐ Hives (Urticaria)_____

_____ _____

Physician Date