Allergy, Asthma, Pulmonary & Internal Medicine Center

Patient's Last Name _____ First Name_____ Middle Initial ____

SSN _____ Date of Birth _____ Age _____ Sex: F M

Address _____ Apt.#_____ City _____ State _____ Zip _____ County_____

Race: _____ Ethnicity_____ Language: _____

Name & Address of Primary Care (Family) Physician / Pediatrician _____

Referring Physician Name & Address (if different) _____

Marital Status: Single Married Divorced Widowed Separated Student Status: PT FT Occupation:_____

Home Phone _____ Day Phone _____ Cell Phone _____

E-mail Address _____

Employer: _____

PHARMACY NAME/ADDRESS: _____**DO NOT LEAVE BLANK!

Name of Spouse/Parent/Legal Guardian _____

Primary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____ Ins. Co. Phone Number _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Secondary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____ Ins. Co. Phone Number _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Is this visit covered by Workers' Comp? _____ No Fault? _____

Emergency Contact: _____ Phone #: _____

Doctor you are here to see _____ I Will Be Paying By: Cash CHECK CREDIT CARD

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received notice of privacy practice.**

Responsible Party Signature: _____ *Date:* _____

Patient Name: _____ DOB:_____ Date:_____

What is the reason you are here today? _____

ALLERGIES TO MEDICINE? Yes / No If yes please list below:

_____

_____

Have you ever had an allergy test? Yes No
Have you ever taken allergy shots? Yes No
If yes, are you still taking them? Yes No How much relief from shots? minimal partial significant

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) or NO MEDICATIONS

Medication Name	**Strength (MG)**	**Dose (how often)**

If additional medications please attach

PAST MEDICAL HISTORY: CIRCLE ALL THAT APPLY BELOW. *IF NO MEDICAL OR SURGICAL HISTORY PLEASE CIRCLE: NO*

CARDIOVASCULAR	**PULMONARY**
Coronary Artery Disease	Asthma
Elevated Cholesterol	Sleep Apnea
High blood Pressure	COPD
	Tuberculosis
ALLERGY	Emphysema
Seasonal Allergy	
Food Allergy	**EAR NOSE THROAT**
Sinus	Chronic Sinus
	Nasal Polyp
GI	Chronic Ear Infection
Hepatitis	Hearing Loss
Gastritis	Dizziness
Ulcer	
EYES	**HEME/BLOOD**
Cataract/Glaucoma	Anemia
Blurry vision	
ENDOCRINE	**URINARY**
Diabetes	Prostrate
Low Thyroid	Kidney Stones
Hyperthyroid	Renal Failure
	PSYCHIATRY

OTHER	Sleep Disorder
	Anxiety/Depression
	Other:

SOCIAL HISTORY

Tobacco History:

Current Smoker: YES/NO Past Smoker: When did you quit? _____

Cigarettes/Day: _____ Past amount of cigarettes: _____

Packs/Day: _____

Alcohol: YES/NO #drinks/week: _____

Family History:

Children: yes/no

How many children:

Do your children have allergies?

REVIEW OF SYSTEMS: CIRCLE ALL THAT APPLY

GENERAL HEALTH	EYE	EAR	NOSE	MOUTH/ THROAT	HEART	LUNG	DIGESTIVE
Fatigue	Red eyes	Hearing loss	Sinus pressure	Swallowing problem	Chest pain	Cough	Abdominal pain
Fever	Itchy eyes	Itchiness	Facial pain	Snoring	Heart racing	Shortness of Breath	Constipation
Night Sweats	Double Vision	Ear pain	Mouth breathing	Hoarse voice	Swelling of ankles	Wheeze	Diarrhea
Weight Loss		Ringing	Nasal drip	Mouth ulcers	Passing out		Heartburn
Weight Gain			Nose bleeds				Nausea
			Runny nose				Vomiting

BRAIN	HORMONES	BLOOD	ALLERGY	SKIN	
Headache	Cold Intolerance	Easy bleeding	Food Allergy	Itchy skin	
Seizure	Heat Intolerance	Easy bruising	Insect Allergy	Rash	
Weakness	Sweating		Hives	Contact Allergy	
Numbness			Eczema		
Insomnia/Sleep distruption			Dry Skin		

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HIPAA Acknowledgement and Designation Disclosure Form

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By signing below, I acknowledge I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Patient Name_____ Signature_____ Date_____

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

HIPAA states your personal health information (PHI) cannot be shared unless you give consent. You have the right to have one or more persons as a personal representative and you can limit the amount of information they receive. By signing and completing below you agree AAIR may disclose your health information to the Personal Representative listed below as of the date given. This Personal Representative Designation will last until you tell AAIR otherwise. To cancel this disclosure, you will have to sign a revoke form and disclosure will seize immediately but does not cancel disclosures given while this agreement was in effect. AAIR will not cancel disclosures until signed written confirmation is received.

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:_____

_____ OK to leave message with detailed information *Initials*

_____Leave message with call back numbers only *Initials*

Work Telephone Number:_____

_____ OK to leave message with detailed information *Initials*

_____Leave message with call back numbers only *Initials*

Email or Fax Communication:_____

_____ OK to fax at the number listed above

_____ E-mail me at:_____

_____ I have read the policy and agree to be bound by all terms and conditions herein.

_____***Name of Patient or Responsible Party Date***

_____***Signature of Patient or Responsible Party Date***

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FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time.

Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

REFERRALS – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

CO-PAYMENTS – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

OUT OF NETWORK PLANS – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to ENT and Allergy Associates for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

SELF-PAY PATIENTS – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

MEDICARE – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be
billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to ENT and Allergy Associates for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. ENT and Allergy Associates, LLP will not be involved with separation or divorce disputes.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

I hereby agree that you may contact me for whatever reason concerning my account on any and all of the phone numbers I have provided to you, including but not limited to home phone, work phone, cell phone or any other phone number.

Patient's Name: _____Responsible Party Signature: _____Print Name: _____

DOB: _____ Date: _____ Relationship: _____