Asthma & Allergy CENTER

Roanoke
1505 Franklin Rd. SW
Roanoke, VA 24016
T (540) 343-7331
F (540) 343-7349

Lynchburg
2015 Tate Springs Rd.
Lynchburg, VA 24501
T (434) 846-2244
F (434) 846-0602

Salem
3529 Keagy Rd.
Salem, VA 24153
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Patient Information Sheet

Account:_____

Patient's Name (Please print and include middle initial)		Sex M F	Marital Status S M W D Sep	Age	Home Phone
Date of Birth	Social Security #	Race/Ethnicity			Cell Phone
Street Address Apt. Number		City	State	Zip Code	Email Address
Primary Care Physician		Address			Phone
Referring Physician		Address			Phone
Emergency Contact		Address			Phone
How did you find out about our office? Other (Please explain):					

If Patient is an Adult

Patient's Employer			Work Phone
Spouse's Name	Spouse's Date of Birth	Spouse's Social Security #	Spouse's Cell Phone
Spouse's Employer			Spouse's Work Phone

If Patient is a Child

Father's Name	Father's Date of Birth	Father's Social Security #	Father's Cell Phone
Father's Address (If different from patient's)	Employer		Father's Work Phone
Mother's Name	Mother's Date of Birth	Mother's Social Security #	Mother's Cell Phone
Mother's Address (If different from patient's)	Employer		Mother's Work Phone

Insurance Information

*We will only bill Primary and Secondary

Name of Primary Insurance	Policy Holder	Birth Date	Policy or ID # Group #
Policy Holder's Address (If different from patient's)			Relationship to patient
Name of Secondary Insurance	Policy Holder	Birth Date	Policy or ID # Group #
Policy Holder's Address (If different from patient's)			Relationship to patient

Signature:_____ Date:_____

Asthma & Allergy CENTER

NEW PATIENT EVALUATION
SECTION I: CLINICAL HISTORY

Nurse's Initials:_____

1. Name: **Age:** **Date:**

Referring Physician: **Office Location:**

2. Chief Complaint: Describe in the patient's own words, the problems that bring them here for evaluation.

a) Have your health problems caused you to miss any work or school days over the past year? If yes, how many? _____

b) Have your family members missed any days of work or school because of your health problems? If yes, how many? _____

c) Have you required emergency treatments or hospitalization for this? How many times in the past year? _____

d) When did your main symptoms first appear?

e) When did the latest attack start and end?

f) How often do you have these problems?

g) How long do they last?

h) Which of these symptoms do you have every day?

3. History of Present Illness: Oculo-Nasal

a) Do you have any eye or nasal symptoms? If no, please skip item #4 below

b) How long have you had these? _____

4. Check those eye or nasal symptoms that apply:

Yes	None	Circle those symptoms that are most severe	
○	○	a) Runny nose / clear, watery	
○	○	b) Blockage (plugged up)	
○	○	Trouble with nose breathing	
○	○	c) Sneezing spells or fits	
○	○	d) Trouble smelling things	
○	○	e) Post-nasal drainage	
○	○	Thick, discolored drainage	
○	○	Thin, clear, watery drainage	
○	○	f) Itching of eyes	
○	○	Of ears	
○	○	Of nose	
○	○	Of throat	
○	○	Of roof of mouth	
○	○	g) Dryness or nose bleeds	
○	○	h) Frequent colds or infections	
○	○	Earaches or ear infections	
○	○	Sinus infections	
○	○	i) Throat tickle with cough	
○	○	j) Throat or face swelling	
○	○	k) Eyes - burning	
○	○	Watery	
○	○	Puffy or swollen eyes	
○	○	l) Frequent headaches	
○	○	Sinus headaches	
○	○	Migraine headaches	
○	○	Tension headaches	

5. History of Present Illness: Pulmonary

a) Do you have any chest symptoms? If no, please skip item #6 below

b) How long have you had these? _____

6. Check those "chest-related" symptoms that apply:

Yes	None	Circle those symptoms that are most severe	
○	○	a) Chest tightness	
○	○	b) Chest congestion	
○	○	c) Frequent cough	
○	○	Nocturnal cough	
○	○	Cough with exertion	
○	○	Cough with laughing or screaming	
○	○	Cough at rest	
○	○	Coughing up discolored mucus	
○	○	Coughing up blood	
○	○	d) Difficulty walking up stairs	
○	○	Difficulty breathing	
○	○	Trouble taking a deep breath	
○	○	Shortness of breath	
○	○	Difficulty running	
○	○	Difficulty walking around	
○	○	Easy fatigability	
○	○	e) Ever diagnosed as asthma	
○	○	f) Do you ever wheeze?	
○	○	Hospitalized for wheezing	
○	○	Wheezing attacks	
○	○	Wheezing with colds	
○	○	Wheezing with exercise	
○	○	Wheezing at night	
○	○	Wheezing at rest	
○	○	g) Snoring	
○	○	h) Mouth breathing	

7. Do you have any skin problems?
If no, please mark "None" in the boxes to the right

a) How long have you had these? _____ if you have hives, welts, swelling, or urticaria, please complete the "Hives Questionnaire"

b) Please describe your skin problem:

Check level of severity →	**None**	**Mild**	**Mod**	**Severe**
a) Generalized itching	○	○	○	○
b) Swelling	○	○	○	○
c) Eczema / Atopic dermatitis	○	○	○	○
d) Skin infections	○	○	○	○
e) Rash with metal	○	○	○	○
f) Poison ivy / oak / sumac	○	○	○	○
g) Psoriasis	○	○	○	○
h) Seborrhea	○	○	○	○

8. Do your symptoms vary with the seasons: If no, tell us if you have them all year or go to section #9

Mark the time of year when you have the following symptoms	All year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Nasal Symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eye symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Chest symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Skin problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

9. Please list any medications you may have taken recently or take on a regular basis and the dose. (include OTC & BCPs) (If you need more space, list them in the unused blocks under item #10)

Medication:	**Dose taken**	**Last dose**

10. Do you have any medication allergy or adverse reactions? If no, please skip this section.

Medication:	**Reaction**	**When**

11. Have you ever been evaluated for allergies in the past?

a) If yes, to what tests were you found to be allergic?

b) Did you receive allergy injections?
How long? Did they help?

When were they stopped?

12. Family History: Circle those medical conditions which may run in your family.
List the relationship of the family member to you in the empty block next to the illness.

Aspirin reactions	☐		Hay fever	☐	
Bronchial asthma	☐		Hiatal hernia	☐	
Blocked nose	☐		Hives	☐	
Diabetes	☐		Migraine headaches	☐	
Eczema	☐		Sinusitis	☐	
Emphysema	☐		Tuberculosis	☐	
Food allergy	☐		Other (specify)	☐	

13. Check those factors below that make your symptoms worse

☐	**a) Weather changes:** Rain, cold fronts, thunderstorms, wind	
☐	**b) Humidity:** High (dampness) or low (dryness)	
☐	**c) Tobacco smoke**	
☐	**d) Smog/air pollution**	
☐	**e) Cold air:** Inside (air conditioning) or outside	
☐	f**) Heat**: Inside or outside	
☐	**g) Perfumes, powder, detergents, air fresheners, hairspray**	
☐	**h) Fumes:** Paint, fuel, insecticides	
☐	**i) Bright sun**	
☐	**j) Inside dust:** Vacuuming, cleaning, sweeping, old books	
☐	**k) Outside dust**	
☐	**l) Stress, worry**	
☐	**m) Exercise or exertion**	
☐	**n) Laughing**	
☐	**o) Grass or hay mowing, fresh cut grass**	
☐	**p) Tree pollen**	
☐	**q) Mold:** Raking leaves, musty basements, mildew, fungi	
☐	**r) Weeds**	
☐	**s) Animals** (list):	
☐	**t) Feathers**	
☐	**u) Other:**	

14. Home/Work Survey: Circle those that apply. If "Yes," fill in the blank as appropriate.

Occupation:

Do any conditions at work make your symptoms worse? _____

Hobbies: _____

Does anything related to your hobby make your symptoms worse? **What?** _____

Home heating:

Home cooling:

Type of bed: **Mattress cover:**

Dust catchers:

Solid flooring: **Window covering:**

Carpets:

Pets:

Are the pets indoor or outdoor? _____

Are you exposed to any other birds or animals? _____

Does anyone who lives at home smoke? Who? _____

If you have smoked, how much and how long? _____

Are there any industries around that house that bother you?

Other

15. If female, are you pregnant or trying to achieve pregnancy? **LMP:**

16. Ancillary Allergy History:

a) Do you have any problems with any foods? Describe:

b) Do you have any problems with insect stings? What kind?

Have you ever had any reactions that were more that large local swelling?
If "Yes," please complete the "Bee Sting Anaphylaxis Questionnaire."

17. Neonatal History: (Circle appropriate answer)

a) Were you breast-fed, bottle-fed, or both?
b) Did you have problems with baby formulas? If so, which ones?
c) Were you premature?
d) Did you have newborn breathing problems?

18. Immunizations:

a) Initial childhood immunization series
b) Tetanus booster in 10 years
c) Chicken pox vaccine
d) MMR booster
e) Typhoid
f) Pneumococcal vaccine
g) Prevnar
h) Hepatitis B series
i) Influenza: (date of last dose) _____

19. Check those medical conditions which you have had in the past

Review of Systems: **Past Medical History:**

Do you suffer from any of the following:		Frequency	Date of last episode	Have you had any of the following conditions:	When?
Sinusitis	☐			Nasal polyps	
Bronchitis	☐			Emphysema	
Pneumonia	☐			Tuberculosis	
Asthma attacks	☐			Diabetes	
Bladder problems	☐			Kidney disease	
Muscle or back trouble	☐			Liver disease or hepatitis A, B, or C	
Arm or shoulder trouble	☐			Carpal tunnel syndrome	
Arthritis	☐			Cancer	
Tendonitis or joint trouble	☐			Chicken pox	
Irregular heartbeat	☐			Heart disease/rheumatic fever/murmur	
High blood pressure	☐			Thyroid	
Alcohol use	☐			Addiction	
Substance abuse	☐			Sinus surgery	
Depression/nervous disorders	☐			Sinus x-rays: Normal:	
Dizziness or vertigo	☐			Sinus CT scan: Normal:	
Bleeding problems or easy bruising	☐			Last chest x-ray	
Hiatal hernia/GERD	☐			Hysterectomy	
Frequent heartburn or stomach ulcers	☐			Nasal polypectomy	
Bedwetting	☐			PE ear tubes, tonsil or adenoidectomy	
Seizures/convulsions	☐			Other Surgeries:	
Hair loss	☐				

19. Additional Comments:

Physician's Signature:_____ **Date: _____**

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Patient Financial Policy

Thank you for choosing Allergy & Immunology, PLC (the Asthma and Allergy Center) as part of your healthcare team. We are committed to building a successful physician-patient relationship with you and your family. Your understanding of our financial policy is an important piece in building that relationship. Please ask our staff If you have any questions about our policies or about your responsibilities.

We require that all patients complete the Patient Financial Policy prior to seeing the provider. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

1. **PAYMENT** is due at the time of service unless other financial arrangements have been made in advance. We require all patients to pay their copay and/or coinsurance payment at the beginning of each visit. After the conclusion of each visit, the patient will be billed for any remaining balance, including, but not limited to the patient's deductible and any uncovered services as contractually allowed. The patient, or responsible party if patient is a minor, is ultimately responsible for payment for any professional services rendered, regardless of insurance.

   By signing this form, you are acknowledging that you understand and authorize that, when requested by you, Allergy & Immunology, PLC will send emailed receipts of payment. These receipts will be transmitted over an unsecure channel and there is a chance they may be intercepted by a 3rd party.

2. **INSURANCE** It is the responsibility of the patient to provide our office with current insurance information and to complete any forms necessary to expedite payment by the insurance provider. The patient is expected to present an insurance card at each visit. A quote of benefits provided by Allergy & Immunology, PLC is not a guarantee of benefits or payment. Insurance coverage is verified as a courtesy and does not guarantee payment. Not all insurance plans cover all services.

   Your insurance policy constitutes a contract between you and the insurance provider. Some insurance plans require precertification or a referral from a primary care physician to cover our services. It is the responsibility of the patient to obtain any precertification or referrals necessary for payment. The patient, or responsible party if the patient is a minor, is ultimately responsible for all charges. Please check with your insurance carrier to verify coverage.

   It is the policy of Allergy & Immunology, PLC to file insurance claims with a primary carrier and one additional secondary carrier. Any additional claims will have to be submitted by the policy holder.

   By signing below, you also request that all payments of authorized Insurance Company benefits

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be made either to you or on your behalf to Allergy & Immunology, PLC for any services furnished to the patient by this office. Regulations pertaining to Medicare assignment of benefits apply.

3. **RETURNED CHECKS** will incur a $50 service charge payable by cash, credit, or money order. This amount will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash or credit only basis following any returned check.

4. **OUTSTANDING BALANCE** It is the policy of Allergy & Immunology, PLC that all past due accounts will be sent two statements. If payment is not made on the account, a single phone call will be made to attempt to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney.

   In the event an account is turned over for collections, the individual financially responsible for the account will be responsible for all collection costs, including attorney fees and court costs. By signing this form, you are acknowledging and authorizing the Collection Agency to contact you via phone (including cellphone), text message, or email with an automated message when applicable. You are acknowledging that you will be responsible for any additional fees issued by your wireless carrier as a result of these calls or messages. You are also acknowledging that you may be required to pay upfront for all services rendered.

5. **MEDICAL RECORDS** requests are processed in timely manner, in accordance with both federal and state law. Patients requesting copies of their medical records will be assessed a charge of $0.25 per page with a $5 minimum charge.

6. **CANCELLATIONS and MISSED APPOINTMENTS** Allergy & Immunology, PLC strives to provide prompt and timely care to all patients. No-Shows or late cancellations prevent other patients from receiving care. Allergy & Immunology, PLC requires 48 hours notice to reschedule appointments. Appointments rescheduled without this notice period may incur a $25 charge. Missed appointments may be charged a $60 fee. These charges are the responsibility of the patient and are not covered by insurance.

7. **MINORS** If a patient is a minor, the parent or guardian who authorizes treatment will be held financially responsible for all professional services provided to the patient by Allergy & Immunology, PLC. If a court order is in force that outlines other arrangements, it must be provided promptly to Allergy & Immunology, PLC.

☐ I, the undersigned, acknowledge that I have read the statements above and agree to the terms and conditions. I accept responsibility for payment of all professional services provided to the patient by Allergy & Immunology, PLC.

Patient Name:_____ DOB:_____

Guardian (if applicable): _____ Relationship:_____

Signature:_____ Date:_____

☐ By selecting, I am acknowledging that my electronic signature is legally binding.

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Privacy Policy Acknowledgement Form

Patient Name:_____ Date of Birth:_____

Guardian/ Representative (if applicable):_____

Relationship to Patient:_____

My signature below indicates that I have been provided with a copy of the Asthma & Allergy Center's Notice of Privacy Practices.

Signature:_____ Date:_____

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Authorization for Use or Disclosure of Information

Patient Name:_____ Date of Birth:_____

Guardian/ Representative (if applicable):_____

Relationship to Patient:_____

I, the undersigned, hereby authorize The Asthma & Allergy Center to disclose the following protected health information (PHI):

Appointments Clinical Notes Labs and other test results

Medications Shot and Vial History

To the following entities:

_____

For the following use or purpose(s):

Ongoing Healthcare

_____

This authorization shall expire:_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Jason Call at the Roanoke address listed above. I understand that a revocation is not effective to the extent that The Asthma & Allergy Center has relied on the use or disclosure of the PHI. I further understand that, in accordance with state and federal law, there may be a charge associated with copying my records. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. The Asthma & Allergy Center will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

Signature:_____ Date:_____