Allergy & Asthma Center of Georgetown

Please provide your insurance card and drivers license to the front desk.

PATIENT INFORMATION

First Name _____ Middle _____ Last Name _____

D.O.B. _____/_____ / _____ Gender ____ Marital Status _____ Email _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Occupation _____ Employer _____

Primary Care/Referring Physician _____

Minors: Guarantor's Name _____ Address _____

Mother's Name/Guardian _____ Father's Name/Guardian _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Ins. Address _____

Policy # _____ Group # _____ Ins. Phone _____

Card Holder Name _____ D.O.B. ____ / ____/ _____ Email _____

Relation _____ Address _____

Employer _____ Work Phone _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Ins. Address _____

Policy # _____ Group # _____ Ins. Phone _____

Card Holder Name _____ D.O.B. ____ / ____/ _____ Relation _____

PATIENT PAYMENTS: By signing below, you agree that payment is due at the time of service. There may be a fee for any appointment not canceled 24 hours in advance.

INSURANCE COVERAGE/AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION:

We make no claim to know what services your insurance covers. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility alone to know what insurance plan you are on; please supply us with the correct information at the time of your visit. Some services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions about covered services. Be aware that some and perhaps all of the services provided may not be covered by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered. If you did not update your insurance information at the time of your visit, you will be responsible for a $25.00 refiling fee. By signing below, you authorize payment of medical benefits directly to the physician. You authorize the physician to release any information acquired in the course of your treatment necessary to process insurance claims.

PROTECTION OF PATIENT PRIVACY: Our clinic policy prohibits video and audio recordings. By signing below, you acknowledge you will not record any interaction on any electronic device in the clinic.

NOTICE OF PRIVACY PRACTICES: By signing below, you acknowledge that you have been given access to the *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein. You must give exceptions, if any, in writing to the Practice.

PHOTOGRAPHS: By signing below, you understand that Allergy & Asthma Center of Georgetown may use your photograph for treatment and identification purposes.

Patient/Guardian Signature _____ Date _____

ALLERGY & ASTHMA CENTER OF GEORGETOWN

CONTACT INFORMATION

I authorize Allergy & Asthma Center of Georgetown to call the phone numbers listed below and leave a message on voice mail or give information to persons in reference to my care at this clinic.

Home Phone _____

Cell Phone _____

Work Phone _____

Other Phone _____

I authorize the clinic to disclose medical information to the persons listed below.

Name	_____	Name	_____
Relation	_____	Relation	_____
Home Phone	_____	Home Phone	_____
Cell Phone	_____	Cell Phone	_____

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Patient/Guardian Signature Date

Name _____ D.O.B._____ / _____ /_____

Primary care physician _____

How did you hear about us _____

Describe the reason for your visit today _____

Preferred pharmacy _____

I. HISTORY OF PRESENT ILLNESS

ALLERGIES

If you have nasal allergies, please indicate your symptoms

☐ Stuffy nose	☐ Sneezing	☐ Bad breath	☐ Itchy throat
☐ Runny nose	☐ Nosebleeds	☐ Hoarseness	☐ Sore throat
☐ Postnasal drip	☐ Snoring	☐ Itchy eyes	☐ Loss of taste
☐ Throat clearing	☐ Loss of smell	☐ Watery eyes	☐ Headache
☐ Itchy nose	☐ Mouth breathing	☐ Itchy ears	☐ Nasal polyps

Other symptoms _____

How long have you had allergies _____ What time of the day is worse _____

Are symptoms year long ☐ Yes ☐ No Which months are worse _____

Indicate if you have allergy symptoms with the following triggers

☐ Trees	☐ Cats	☐ Windy days	☐ Alcoholic beverages
☐ Grass	☐ Dogs	☐ Cold temperatures	☐ Spicy foods
☐ Weeds	☐ Feathers	☐ Fragrances	☐ Exercise
☐ Molds	☐ Smoke	☐ Strong odors	☐ Menstrual cycle
☐ Dust	☐ Smog	☐ Chemicals	☐ Stress

Other triggers _____

How often do you have sinus infections _____

If you have had CT scans of your sinuses, list the dates _____

If you have had skin testing, list the dates _____

If you have been on allergy injections, list the dates _____

ASTHMA

If you have asthma, when were you diagnosed _____ Please indicate your symptoms

☐ Daytime symptoms	☐ Difficulty getting air in	☐ Chest tightness
☐ Nighttime symptoms	☐ Difficulty getting air out	☐ Wheezing
☐ Shortness of breath	☐ Symptoms with exercise	☐ Cough

Other symptoms _____

Name _____ D.O.B._____ / _____ /_____

What triggers your asthma symptoms _____

What time of the year does your asthma worsen _____

Is your physical activity restricted due to asthma ☐ Yes ☐ No

How often do you use your rescue inhaler _____

How often have you needed steroids for asthma _____

Number of missed school/work days due to asthma _____ Number of ER visits for asthma _____

Number of hospitalizations for asthma _____ Have you ever been intubated ☐ Yes ☐ No

If you have had CT scans of your chest, list the dates _____

ECZEMA OR RASHES

Do you have eczema ☐ Yes ☐ No When did it start _____

Describe your rash _____

What medicines have you used for the rash _____

What soaps and lotions do you use _____

Have you had a biopsy ☐ Yes ☐ No If yes, when _____

HIVES OR SWELLING

Do you have hives or swelling ☐ Yes ☐ No When did it start _____

Describe your symptoms _____

What have you used for the symptoms _____

Have you had a biopsy ☐ Yes ☐ No If yes, when _____

OTHER ALLERGIES

Do you have a food allergy ☐ Yes ☐ No

If yes, list the foods and reactions _____

Do you continue to eat these foods ☐ Yes ☐ No

Have you had a life-threatening reaction to an insect sting ☐ Yes ☐ No

If yes, list the insects and reactions _____

II. PAST MEDICAL HISTORY

Please indicate if you have been diagnosed with the following conditions

☐ Heart disease	☐ Diabetes	☐ Hypertension	☐ Depression
☐ Sleep apnea	☐ Cataracts	☐ High cholesterol	☐ Anxiety
☐ Pneumonia	☐ Glaucoma	☐ Thyroid disease	☐ Cancer
☐ COPD	☐ Reflux disease	☐ ADHD	☐ HIV/AIDS

Other medical conditions _____

If you had the following surgeries, list the dates

Sinus surgery _____ Tonsillectomy _____ Adenoidectomy _____ Ear tubes _____

Other surgeries _____

List the dates for the following vaccines: Influenza _____ Pneumococcal ("Pneumonia") _____

Name _____ D.O.B._____ / _____ /_____

List all your current medications including vitamins and supplements.

Medication	Dosage	Frequency

Do you have an epinephrine autoinjector ☐ Yes ☐ No

List any medication allergies and reactions _____

_____

Are you allergic to latex ☐ Yes ☐ No If yes, what are your symptoms _____

III. SOCIAL HISTORY

Occupation _____ Who lives at home with you _____

Marital status _____ If you have children, list their ages _____

Do you currently smoke ☐ Yes ☐ No If yes, # of cigarettes per day _____ For how long _____

Did you smoke in the past ☐ Yes ☐ No If yes, # of cigarettes per day _____ For how long _____

When did you quit _____

Do you drink alcohol ☐ Yes ☐ No If yes, how often _____

Do you use illicit drugs ☐ Yes ☐ No If yes, what kind and how often _____

Is there anyone who smokes in your home ☐ Yes ☐ No

If yes, where do they smoke ☐ Indoors ☐ Outdoors

If you exercise, what type and how often _____

List your hobbies _____

ENVIRONMENTAL HISTORY

Do you have pets ☐ Yes ☐ No What kind and how many _____

Do the pets live ☐ Indoors ☐ Outdoors Do the pets sleep in the bedroom ☐ Yes ☐ No

How old is your home _____

What types of plants are around your home _____

What flooring/window coverings are in your bedroom _____

How long have you lived in Central Texas _____

Where did you live prior to Central Texas _____

Name _____ D.O.B._____ / _____ /_____

IV. CHILDREN UNDER 12 YEARS OLD

Were there any complications with the pregnancy or at birth _____

Does the child stay in day care ☐ Yes ☐ No What grade is the child in _____

If the child has siblings, list their ages _____

Has the child had RSV infection ☐ Yes ☐ No

V. FAMILY HISTORY

If anyone in your family has been diagnosed with the following conditions, please specify the relation

Asthma _____ Food allergy _____ Hives _____

Hay fever _____ Eczema _____

Other medical conditions in the family _____

Father's age _____ If deceased, age and cause of death _____

Mother's age _____ If deceased, age and cause of death _____

VI. REVIEW OF SYSTEMS

Indicate if you have the following symptoms

☐ Fever	☐ Weight gain	☐ Abdominal pain	☐ Visual changes
☐ Chills	☐ Weight loss	☐ Urinary infections	☐ Dizziness
☐ Fatigue	☐ Cold intolerance	☐ Blood in stools	☐ Fainting
☐ Chest pain	☐ Heat intolerance	☐ Insomnia	☐ Muscle pain
☐ Palpitations	☐ Nausea	☐ Anxiety	☐ Joint pain
☐ Leg swelling	☐ Vomiting	☐ Memory loss	

Other information to assist in your care_____

_____

_____

_____

_____

_____

Patient/Guardian Signature _____ Date _____

Physician Signature _____ Date _____