Adult New Patient Information

Name Patient Goes By _____

Patient Full Name _____ Gender M / F _____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Alternate Phone _____ Phone Type _____

Employer _____ Occupation _____

Referring Doctor _____ Referring Doctor Phone _____

Primary Care Physician (PCP) _____ PCP Phone Number _____

Patient's E-mail Address _____ E-Mail Type work / home

Have we seen any of your family members before? YES / NO If yes, patient's name _____

Marital Status MARRIED / SEPARATED / DIVORCED / WIDOWED / SINGLE

INSURANCE INFORMATION

Insured Under: ☐ Self ☐ Spouse ☐ Other

Employer _____ Occupation _____

Insurance Company _____ Eligibility / Benefits Phone _____

Policy ID Number / Subscriber ID _____ Group Number _____

Please provide the following information on the insured person. If you are self - insured, please leave this section blank.

First Name _____ Middle Initial _____ Last Name _____

Gender M / F _____ DOB _____ Relationship to Patient _____

Street Address _____ Home Phone _____

City _____ State _____ Zip Code _____ Work Phone _____

EMERGENCY CONTACT INFORMATION

Emergency Contact information will be utilized when we are unable to reach you at any of the above given phone numbers / address.

Primary Contact (not living with patient) _____ Phone Number _____

Address _____ Relationship to Patient _____

PHARMACY INFORMATION

Please provide the information for your local pharmacy. The information listed here will be used to call in prescriptions when refills or new prescriptions are needed.

Pharmacy _____ Phone Number _____

Address _____

How Did You Hear About Us ?

_____

_____

8440 Walnut Hill Lane Suite 350 Dallas, Texas 75231
3600 Communications Parkway, Suite 675 Plano, Texas 75093

(214) 373-1773 Fax (214) 373-1316
(972) 473-7544 Fax (972) 473-7545

ADULT MEDICAL HISTORY

AIR Care
Allergy, Immunology & Respiratory Care, PA

Patient Goes By: _____

Patient Name: _____ ID #: _____ Sex: M / F Age: _____ Date: _____

Immunizations up to date: *Diptheria/ Tetanus Vaccine* ☐Yes ☐No *Prior Flu Vaccine* ☐Yes ☐No *Pneumovax/Prevnar* ☐Yes ☐No

Current Allergy or Asthma Medications _____

Prior Allergy or Asthma Medications (did they help or were there problems) _____

Current Other Medications _____

Current vitamins, herbals or non-prescription meds _____

Drug Allergies or Reactions

Medication _____ Approximate Date _____ Describe Reaction _____

Hospitalizations

Age _____ Reason _____ Hospital _____

Surgeries

Age _____ Type of Surgery _____ Results _____

Family History	**Mother**	**Father**	**Brothers**	**Sisters**	**Other**
Tuberculosis or Other Lung Diseases	☐	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐	☐
Chronic Bronchitis or Emphysema	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Nasal or Sinus Allergies	☐	☐	☐	☐	☐
Eczema or Skin Rashes	☐	☐	☐	☐	☐
Food Allergies	☐	☐	☐	☐	☐
Drug or Medication Allergies	☐	☐	☐	☐	☐
Stinging Insect Reactions	☐	☐	☐	☐	☐
Allergy or Sensitivity to Aspirin	☐	☐	☐	☐	☐
Recurrent Infections or Pneumonia	☐	☐	☐	☐	☐
Immune System Disorders	☐	☐	☐	☐	☐
HIV / AIDS	☐	☐	☐	☐	☐

Social History

Exposure to cigarette/cigar smoke ☐ yes ☐ no _____

Pets at home ☐ yes ☐ no ☐ cat ☐ dog ☐ other _____

Pets away from home ☐ yes ☐ no ☐ cat ☐ dog ☐ other _____

Living Environment ☐ Apartment ☐ Home Age of Apt. / Home: _____ Foundation: Pier & Beam Slab

Wall to Wall Carpeting
In house ☐ yes ☐ no
In bedroom ☐ yes ☐ no

Ceiling Fans in Bedroom ☐ yes ☐ no

Pets sleep on your Bed ☐ yes ☐ no

Humidifiers in House ☐ yes ☐ no

Water Leaks/Contamination ☐ yes ☐ no

Pillow Type: synthetic down/feather Allergy encased/ proofed yes no

Bed Cover Type: synthetic cotton down/feather Allergy encased/ proofed yes no

Are you aware of any work related exposures: _____

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ADULT MEDICAL HISTORY

AIR Care
Allergy, Immunology & Respiratory Care, PA

Patient Goes By:_____

Patient Name: _____ ID #: _____ Sex: M / F Age: _____ Date: _____

Review of Systems:

Please check all conditions you have currently or have had in past.

HEART ☐ none

☐ chest pain
☐ irregular heart beat
☐ skipped beats
☐ palpitations
☐ other _____
☐ high blood pressure
☐ high cholesterol
☐ stroke
☐ heart failure
☐ heart attack

DIGESTIVE ☐ none

☐ chronic nausea or vomiting
☐ indigestion or heartburn
☐ gastric reflux
☐ stomach ulcers
☐ other _____
☐ bloating or cramping
☐ diarrhea
☐ constipation
☐ colitis or diverticulitis
☐ Crohn's disease

URINARY ☐ none

☐ burning urination
☐ odor on urination
☐ other _____
☐ dribbling or incontinence
☐ difficult urination
☐ blood in urine

REPRODUCTIVE ☐ none

FEMALE	MALE
☐ pregnant or anticipating pregnancy	☐ infertility problems
☐ miscarriages or infertility problems	☐ cysts or tumors
☐ cysts or tumors	☐ undescended testis
☐ other _____	☐ other _____

SKELETAL ☐ none

☐ fractures
☐ retained baby teeth / delayed permanent teeth
☐ scoliosis or spine abnormalities
☐ other _____
☐ arthritis or joint pain
☐ joint swelling
☐ hyper extendable joints
☐ osteoporosis

NEUROLOGICAL ☐ none

☐ headaches
☐ seizures
☐ fainting / black outs
☐ other _____
☐ dizziness
☐ numbness
☐ depression
☐ insomnia or trouble sleeping

ENDOCRINE ☐ none

☐ thyroid problems
☐ growth or pituitary problems
☐ diabetes
☐ other _____

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AIR Care
Allergy, Immunology & Respiratory Care

PHARMACY INFORMATION

Pharmacy's Name:

_____

Address: _____

City: _____ State: _____ Zip Code: _____

Pharmacy's Phone Number: _____

Pharmacy's Fax Number: _____

MEDICATIONS	INSTRUCTIONS	DOSE/STRENGTH

AIR Care
Allergy, Immunology & Respiratory Care

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

CONSENT FOR MEDICAL SERVICES

I consent to treatment, diagnostic and/or therapeutic services as ordered by a physician of Air Care Allergy Immunology & Respiratory Care PA and his/her designee(s).

FINANCIAL AGREEMENT

The undersigned individually obligates him/herself and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. Payment of any unpaid balance is due within 30 days of final billing. If payment is not received within 30 days of the date of final billing, finance charges may begin to accrue at the maximum rate allowable by law. In addition such balance may be turned over for collection activity, at which time the undersigned shall be liable for attorney's fees and/or collection agency's fees and expenses. The undersigned understands that he/she has the right to examine Air Care Allergy Immunology & Respiratory Care PA credit bureau files for financial information regarding collection or unpaid debt.

ASSIGNMENT OF BENEFITS

In the event that I am entitled to physician benefits of any and all types, I assign such benefits to Air Care Allergy Immunology & Respiratory Care PA for services rendered to me. I authorize payment directly to Air Care Allergy Immunology & Respiratory Care PA of all such insurance benefits payable to me. Such insurance includes, but is not limited to, private commercial insurance, auto/liability insurance, or any governmental program such as Medicare, Medicaid or Worker's Compensation and authorize Air Care Allergy Immunology & Respiratory Care PA to release medical information to such insurance providers as necessary to satisfy conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is accurate and current.

RELEASE OF INFORMATION

I also authorize Air Care Allergy Immunology & Respiratory Care PA to release all or part of my medical record information when required or permitted by law or government regulation, including any physician(s) or healthcare provider responsible for continuing my care.

INSURANCE PRECERTIFICATION

I understand that, before service is rendered, I personally am responsible for any required notification to my insurance company to obtain authorization for treatment. If this is not done, insurance benefits may be reduced and I am responsible for all charges not covered by my insurance.

LIFETIME MEDICARE B & MEDIGAP SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in the Air Care Allergy Immunology & Respiratory Care PA, including physician services. I authorize any holder of medical or other information about me to release to the Centers of Medicare & Medicaid Services or its agents any information needed to determine these benefits or benefits for related services.

_____
Name of Beneficiary

_____
HIC Number

LIFETIME MEDIGAP SIGNATURE AUTHORIZATION

I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits for related services.

_____
Name of Medigap Insurer

_____
Name of Beneficiary

_____
Medigap Policy Number

CONSENT FOR MEDICAL SERVICES & TREATMENT

I have been provided with a copy of the HIPAA Notice of Privacy Practices that describes how Air Care Allergy Immunology & Respiratory Care PA may use and disclose my health information, and also describe my rights regarding my health information.

EVALUATION OR SERVICES AND FOLLOW UP

I give permission for Air Care Allergy Immunology & Respiratory Care PA and/or it's agent(s) to contact me for the purpose of evaluation of the services rendered to me.

☐ YES ☐ NO

_____ _____/_____/____
Signature of Patient or Legally Authorized Representative — *Print* Name of Patient or Legally Authorized — Date

_____ _____/_____/____
Signature of Guarantor of Payment (state relationship if other than patient) — *Print* Name of Guarantor of Payment — Date

AIR Care
Allergy, Immunology & Respiratory Care

Notice of Privacy Practices (NPP)

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information: 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities to maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____
Name of Patient

Patient's Signature : _____ ***Date:*** _____

_____
Name of Patient Representative

Representative's Signature: _____ ***Date:*** _____

FOR INTERNAL USE ONLY

_____ _____
Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

- ☐ Patient was unable to sign
- ☐ Patient refused to sign
- ☐ Other: _____