Child New Patient Information

Patient Full Name _____ AIR Care's Pt. ID No. _____

Name Patient Goes By _____ Date of Birth _____ Gender M / F _____

Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Alternate Phone _____ Phone Type _____

Referring Doctor _____ Referring Doctor Phone _____

Primary Care Physician _____ PCP Phone Number _____

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

Name of Child's School _____ School's Phone No. _____

Parent's Marital Status: MARRIED / SEPARATED / DIVORCED / WIDOWED / SINGLE

Insured Parent's Information

First Name _____ Middle Initial _____

Last Name _____ Gender F / M

Relationship to Patient _____

Street Address _____

City _____

State _____ Zip Code _____ DOB _____

Home Phone _____

Employer _____

Occupation _____

Work Phone _____

E-mail Address _____

Insurance Company _____

Policy ID Number _____

Group Number _____

Forms of acceptable communication: *(circle all that apply)*

phone / cell / postal mail / e-mail

Other Parent's Information

First Name _____ Middle Initial _____

Last Name _____ Gender F / M

Relationship to Patient _____

Street Address _____

City _____

State _____ Zip Code _____ DOB _____

Home Phone _____

Employer _____

Occupation _____

Work Phone _____

E-mail Address _____

How did you hear about us?

_____

_____

EMERGENCY CONTACT INFORMATION

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

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

Address _____ Relationship to Patient _____

Secondary 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 _____

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

CHILD MEDICAL HISTORY

Name Patient Goes by:_____

Name_____ **Pt#**_____ **Sex M / F Age**_____ **Date**_____

Birth: Weight _____ ☐ Full-term ☐ Pre-term (# weeks) _____ Complications _____

Growth: ☐ OK ☐ Delayed or Concerns _____

Development: ☐ OK ☐ Delayed or Concerns _____

Grade in School _____ School Performance ☐ OK ☐ Concerns _____

Immunizations up to date: ☐ Yes ☐ No Prior Flu Vaccine ☐ Yes ☐ No Chicken Pox Vaccine ☐ Yes ☐ No

Current Allergy or Asthma Medications _____

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

Current Other Medications _____

Drug Allergies or Reactions

Medication _____ Approximate Date _____ Describe Reaction _____

Medication _____ Approximate Date _____ Describe Reaction _____

Medication _____ Approximate Date _____ Describe Reaction _____

Hospitalizations

Age _____ Reason _____ Hospital _____

Age _____ Reason _____ Hospital _____

Age _____ Reason _____ Hospital _____

Surgeries

Age _____ Type of Surgery _____ Results _____

Age _____ Type of Surgery _____ Results _____

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 smoke ☐ yes ☐ no _____

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

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

Daycare or weekly group exposure ☐ yes ☐ no

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

Wall to Wall Carpeting

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

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

Ceiling Fans in Bedroom ☐ yes ☐ no

Stuffed Animals on Bed ☐ yes ☐ no

Humidifiers in House ☐ yes ☐ no

Water Leaks/Contamination ☐ yes ☐ no

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CHILD MEDICAL HISTORY

Name Patient Goes by:_____

Name_____ **Pt#**_____ **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/vomiting or spitting up
- ☐ indigestion or heartburn
- ☐ gastric reflux
- ☐ stomach ulcers
- ☐ other _____
- ☐ bloating or cramping
- ☐ diarrhea
- ☐ constipation
- ☐ colitis
- ☐ blood in stool

URINARY ☐ none

- ☐ burning urination
- ☐ odor on urination
- ☐ other _____
- ☐ dribbling or incontinence
- ☐ difficult urination
- ☐ blood or cloudiness inurine

REPRODUCTIVE ☐ none

FEMALE

- ☐ cysts or tumors ☐ on birth control pills
- ☐ periods regular ☐ periods irregular
- last period date _____
- ☐ other _____

MALE

- ☐ torsion or orchitis
- ☐ cysts or tumors
- ☐ undescended testis
- ☐ other _____

SKELETAL ☐ none

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

NEUROLOGIC ☐ none

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

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	START DATE

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: _____

AIR Care
Allergy, Immunology & Respiratory Care

Late Cancellation and No-Show Policy

This policy has been established to provide the highest level of service to all our patients. It has been proven that consistent attendance provides for the greatest opportunity for better health and success. By providing us notice of a cancellation, we can accommodate other patients with your appointment slot.

- Patients must call at least 24 hours prior to their scheduled time, when they knowingly are unable to make their appointment. Cancellations within or less than 24-hours of the appointment will be considered a late cancellation.
- We do understand emergencies arise and it may not be possible to give a 24 hour notice. Exceptions to the Late Cancellation/No-Show policy will be made based on your cancellation history and your provider.
- As a courtesy, patients will receive telephone reminders of the appointment date and time two business days prior to scheduled appointment (unless the patient chooses not to be called). Patients will be provided copies of their scheduled appointments. It is your responsibility to provide us the correct contact information.
- Cancellations can be made anytime by calling our office.

Cancellation Notice Requirements:

Office Visit: 24 hours advance notice.
Failure to provide the required notice will result in a **cancellation fee of $50.00.**

Procedure Visits: 48 hours advance notice
Failure to provide the required notice will result in a **cancellation fee of $100.00.**
This will be charged on all cancelled or no shows for patch testing, intradermal testing, allergy testing, food challenges, antibiotic challenges, and RUSH immunotherapy.
OIC patients will be handled on an individual basis.

Thank you for trusting us with your medical care and your cooperation in helping us to provide quality care and service to all our patients.

The undersigned acknowledges receipt of Allergy, Immunology, and Respiratory Care's Late Cancellation and No-Show Policy:

_____ _____
Patient Signature Date

_____ _____
Printed Name Date

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