Allergy & Asthma Specialists, P.C.
Committed to Lifelong Allergy Relief

New Patient Information

Welcome to our Office

Date _____

PATIENT'S NAME (PLEASE PRINT)	S.S.#	MARITAL STATUS	SEX	BIRTH DATE	AGE
STREET ADDRESS	CITY & STATE			ZIP CODE	HOME PHONE
RACE	LANGUAGE	ETHNICITY			
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)				BUS. PHONE
EMPLOYER STREET ADDRESS	CITY & STATE				BUS PHONE
SPOUSE OR PARENT'S NAME	S.S.#	BIRTH DATE			
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)				BUS. PHONE
EMPLOYER STREET ADDRESS	CITY & STATE				ZIP CODE
PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS CITY & STATE			ZIP CODE	HOME PHONE
PRIMARY INSURANCE (NAME & ADDRESS)	INSURED PERSON	POLICY		GROUP	PHONE
SECONDARY INSURANCE (NAME & ADDRESS)	INSURED PERSON	POLICY		GROUP	PHONE
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE	ADDRESS		
PHARMACY ADDRESS & PHONE#					

As a courtesy, our office will file my insurance on my behalf, however, any co-payment, deductible, or co-insurance is due at the time of service. I understand that the bill incurred at this office is ultimately my responsibility and I agree to pay my account in full in the event my insurance does not pay for the services rendered. It is my responsibility to dispute any disagreement with the way a claim has been paid, however; our office will assist in any way possible.
I have read the above agreement and fully understand that payment policy of this office and agree to the terms stated above.

Date _____ Signed _____

HAS A MEMBER OF YOUR FAMILY BEEN TREATED BY OUR PHYSICIAN BEFORE?			
REFERRED BY	STREET ADDRESS CITY & STATE	ZIP CODE	PHONE
FAMILY PHYSICIAN	PHONE	FORMER ALLERGIST (IF ANY)	PHONE

I hereby release and give my permission to Dr. Rayasam V. Prasad (and/ or his associates) to administer treatment and to perform such procedures as may be deemed medically necessary in the diagnosis and/or treatment of my medical condition. I give my consent to have all treatment.

Date _____ Signed _____

J331

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We are looking forward to having you as our patient. Please complete this form (all four pages) and bring it with you. We will help you to fill any blanks. If you need more space, use a separate sheet. Thank you.

Allergy History Form

Name:	Sex:	Date of Birth:
Date of Visit:	Referred by:	Telephone #:

TO BE COMPLETED BY PATIENT

Main Symptoms	For How Long?
1.	
2.	
3.	
4.	
5.	

Office Use Only ***(PLEASE DO NOT WRITE BELOW)***

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TO BE COMPLETED BY PATIENT	OFFICE USE ONLY

Have You Had These Symptoms? For How Long?

Nasal: --[ ] Runny [ ] Itchy [ ] Stuffy _____
[ ] Mouth Breathing [ ] Headaches
[ ] Pain over Sinuses [ ] Post Nasal Drip
Frequent-- [ ] Throat Clearing [ ] Sore Throats
[ ] Hoarseness [ ] Sneezing [ ] Sniffles
Itching of-- [ ] Throat [ ] Roof of Mouth
Eyes: [ ] Red [ ] Itchy [ ] Pain [ ] Watery Discharge _____
[ ] Foreign Body Sensation
Ears: [ ] Pain [ ] Itching [ ] Discharge [ ] Ringing _____
[ ] Fullness [ ] Decreased Hearing [ ] Infections
Chest: [ ] Tightness [ ] Shortness of Breath
[ ] Wheezing [ ] Persistent Coughing
[ ] Exercise Intolerance
Skin: [ ] Whelps [ ] Chronic Skin Rash [ ] Chronic Itching _____
Excessive-- [ ] Fatigue [ ] Irritability [ ] Tension--
[ ] Sleep Disturbances [ ] Work Absences _____

Past Allergy History

[ ] Croup [ ] Asthma [ ] Bronchitis [ ] Emphysema
[ ] Pneumonia [ ] Nasal Polyps [ ] Nasal Trauma
[ ] Sinus/Nasal / Ear Operations [ ] Repeated Ear Infections
[ ] Repeated Sinus Infections [ ] Migraines
[ ] Prior Allergy Testing, Doctor _____ Year _____
Positive to _____
_____
[ ] Allergy Shots, When _____ How long _____ [ ] Helped
[ ] Reaction to Allergy shots
Repeated exposure to rubber/latex products [ ] Yes [ ] No
(For example: gloves, catheters, and adhesive tape)
Reactions to these products _____

Insect Sting Reactions

[ ] Local [ ] Large (larger than 2") Local [ ] Systemic, Symptoms
_____
_____
Date of-- Last Sting _____ Last Reaction-- _____ [ ] Sting Kit

Seasonal History: Please Rate Severity of Symptoms From + to ++++

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Nasal/Ear												
Eye												
Chest												
Skin												
Tension/Fatigue												

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TO BE COMPLETED BY PATIENT	OFFICE USE ONLY
Adverse Reactions to Foods? _____ If Yes, to What _____ Nature of Reactions to Foods _____ _____ **Aggravating Factors** [ ] House Dusts [ ] Other Dusts, Specify _____ [ ] Feather Pillows [ ] Wool Blankets [ ] Cut Grass [ ] Raking Leaves [ ] Hay [ ] Damp Basements [ ] Lake Shore [ ] Humidifiers [ ] Rainy/Muggy Days [ ] Sunny/Hot [ ] Weather Changes [ ] Cold Air [ ] Air Conditioning [ ] Paints [ ] Perfumes [ ] Cosmetics [ ] Hair Sprays [ ] Other Aerosols [ ] Car Exhausts [ ] Cigarette Smoke [ ] Sleep [ ] Exercise [ ] Emotional Upsets [ ] Cats [ ] Dogs [ ] Other Animals _____ [ ] Other Aggravating Factors _____ _____ Does (Did) the Patient (or Parents) Smoke? _____ If yes, for How Long? _____ How Much? _____	
Environmental Factors Live in [ ] House [ ] Apartment [ ] Other _____ For How Long? _____ Age of home _____ [ ] Ceiling Fans, Air Conditioning: [ ] Central [ ] Room [ ] None Filter Changed Once in _____ [ ] Electronic or HEPA Filters Heating: [ ] Gas [ ] Electric [ ] Hot Water [ ] Wood Burning Windows [ ] Open [ ] Closed, [ ] Humidifiers Type _____ [ ] Visible Mold and / or moisture [ ] Standing / Leaking Water [ ] Cats [ ] Dogs [ ] Other pets, Specify _____ Pets Move Around-- [ ] Indoors [ ] Outdoors [ ] Bedroom-- Plants: [ ] Indoors [ ] Outdoors [ ] Bedroom [ ] Live [ ] Artificial Carpet [ ] Yes [ ] no, Floor in Bedroom _____ Type of Mattress _____ Age of Mattress _____ Type of-- Pillows _____ Blankets _____ Comforters-- _____ Brand of-- Soap _____ Laundry Products _____ Cosmetics _____ Skin Creams--_____	
Work History Occupation _____ Exposure to Any Chemical Dust or Vapors? _____ If Yes, to What? _____ Symptoms worse-- [ ] At Work [ ] Weekends [ ] Vacations--	
❑ Medication Allergies ❑ No Known Drug Allergies Medication | Date of reaction & symptoms 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	

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TO BE COMPLETED BY PATIENT | OFFICE USE ONLY

Medications used in the past for treating the "allergy & asthma".

Medication	Helped Yes / No	Side Effects
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Other medications patient is using _____

General Medical History

- ❑ High BP (on _____)
- ❑ Heart Disease (on _____)
- ❑ Diabetes (on _____)
- ❑ Thyroid Problems (on _____) ❑ Anemia
- ❑ Anxiety / Depression and / or psychological problems(on)
- ❑ Chronic Fever ❑ Unexplained weight loss or gain
- ❑ Heart Burn ❑ Indigestion ❑ Food Regurg
- ❑ Chronic Vomiting or Diarrhea ❑ Chronic Skin Problems
- ❑ Arthritis (on_____)

List significant health problems not already mentioned

_____

_____

Surgeries not already mentioned _____

_____

Hospitalizations for other than surgeries and child birth

_____

_____

❑ Frequent ER visits

Is the patient pregnant? _____

_____

Children/Infants

Neonatal Problems _____

Excessive-- [ ] Spitting [ ] Colic [ ] Breast Fed [ ] Formula

[ ] Changes in Formula, if Yes, why? _____

Formula Tolerated _____ [ ] Immunizations Up to Date

Developmental Mile stones [ ] Normal [ ] Delayed

_____

Family Medical History

[ ] Asthma [ ] Sinus/Hay Fever [ ] Skin Allergies

[ ] Food Allergies [ ] Insect Sting Allergies

[ ] Medication Allergies, Specify _____

[ ] Migraine [ ] Hypertension [ ] Heart Disease [ ] Diabetes

[ ] Others, Specify _____

Completed by _____ Relatinship to Patient _____

Signature _____

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF INFORMATION PRACTICES

I understand that as part of my healthcare, Allergy & Asthma Specialists, P.C., originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- I authorize my protected health information to be reviewed for preparatory to research purposes by Allergy and Asthma, PC, and/or its designated business associates or affiliated research organization for consideration and for contacting me to discuss my potential participation in possible upcoming clinical trials. Such authorization does not expire unless I request an expiration date in writing.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Allergy & Asthma Specialists, P.C. reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to see and obtain copies of my medical record. I understand that I have the right to request amendments be made to my medical record. I understand that a six-year history of all disclosures will be accessible to me including the purpose of the disclosure and the address of the recipient. I may receive a copy of this history within 60 days of my request and I understand that I may have to pay a reasonable charge per page for any copies after the first requested in a 12-month period. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Allergy & Asthma Specialists, P.C. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Allergy & Asthma Specialists, P.C. has already taken action in reliance theron. I have had a chance to have all my questions answered prior to signing this consent form.

____ I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____ _____

Signature of patient or legal representative Date

___ Accepted___ Denied _____

Signature Title Date