PREMIER ALLERGIST
formerly Allergy & Asthma Center

Part of the AllerVie HEALTH Network

Premier Allergist-premierallergist.com

Patient Registration Form

First_____ Last_____ D.O.B_____

Address_____

City_____ State_____ Zip_____

Phone_____ Work_____ Sex: M, F, Other_____

Marital Status: S, M, D, W Social Security#_____ Email_____

Emergency Contact_____ Phone_____ Relationship_____

Insurance Information

Primary Insurance_____ ID #_____ Group_____

Guarantor Name _____ **D.O.B.**_____**Phone**_____

Guarantor's Address_____

Secondary Insurance_____ ID #_____ Group_____

Guarantor Name_____ **D.O.B.**_____**Phone**_____

Guarantor's Address_____

Reference

Referred By (How did hear about us) _____ **Phone**_____

Acknowledgement

I understand that it is my responsibility and I agree to provide Premier Allergist with current and accurate billing information. I agree to notify the office if there are any changes to the above information. I authorize the release of any information necessary to process medical claims. It is strongly recommended that I verify my own coverage.

Patients/or Guardian's Name (Print)_____ Relationship_____

Patients/or Guardian's Signature _____ **Date:**_____

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Payment Acknowledgement/Financial Obligation

Your clear understanding of our policies is important to our professional relationship. We are pleased to discuss and answer questions/or concerns regarding our policy, fees and your financial responsibility at any time requested.

First Name_____ Last Name_____ D.O.B_____

I understand, accept responsibility, and agree that:

- **By law,** we must collect Copays/Coinsurances and unmet deductibles. Copays/Coinsurances and balances over $50 are due prior to services being rendered.
- Self-pay patient payments are required **at time of service** unless other financial agreements have been made prior to your visit.
- I must give 24-Hour cancellation/reschedule notice, if I am unable to provide notice, I will be charged a $50 no show/late cancellation fee.
- **If my account is placed with a collection agency, my account will be charged an additional 30% of the total balance due for which I will be responsible.**
- Any returned checks from my financial institution is my responsibility to pay a returned check fee, in addition to paying the dollar value of the returned check.
- If an allergy serum order has been filled (per consent form) without one month prior **written notice to discontinue** then I will be responsible for the cost of serum. **Verbal discontinuation of serum is not permitted.**
- **In/Out of Network Plans: It is my responsibility to verify my benefit coverage and I am responsible for any balance my plan indicates as on their explanation of benefits.** If we do not participate with your plan, we will send a courtesy bill to your insurance on your behalf. However, should they not pay your claim, you will be responsible for the full amount due. **Should I receive payment from my insurance carrier I agree to forward the payment to Premier Allergist.**
- If a referral is required by my plan from my PCP, it is my responsibility to obtain one prior to my appointment to bring in the day of service. If I do not have a referral, a signed referral waiver is required, which states that **I will be responsible for any services received and not pre-authorized.**
- Divorced/Separated Parents of Minor Patients: **Premier Allergist will not be involved with separation disputes.**
- I understand there's a **per-page** fee for medical records and medical forms for school/sports/daycare providers/FMLA, etc.

Patient/Guardian (print)_____ Date_____
Patient/Guardian Signature_____ Relationship_____

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HIPAA Privacy Authorization Form

To our valued patients:

We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of Personal Health Information (PHI) in accordance with governmental rules, regulations, and laws. We want to ensure that our practice never contributes in any way to growing improper disclosure of PHI. As part of this plan, we have implemented a compliance program that we believe will help us prevent any inappropriate use of PHI. You have the right to review our privacy notice, to request restrictions, and to revoke the consent in writing after you have reviewed our privacy notice.

I authorize Allergy & Asthma Center to use and disclose my PHI to the following individuals:

- ☐ Any member of my family
- ☐ Only with the following individuals: _____
- ☐ I do not give permission to share any of my medical information

The authorization for the release of information covers the period of healthcare from:

- ☐ Until cancelled by me in writing
- ☐ From ___/___/___ to ___/___/___

The person may use this medical information for medical treatment or consultation, billing, or claims payment, or other purposes I may direct. I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state.

Patient's Name and/or Authorized Representative: _____

Relationship to Patient: _____

***Patient's Signature and/or Authorized Representative: _____**

Date Signed: ___/___/___

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Authorization to send medical notes to your primary care physician

_____ _____

Patient Last Name: Patient First Name:

_____ _____

Primary Care Physician Last Name or Practice: Primary Care Physician First Name:

Physician Address:_____

City_____ State_____ Zip_____

_____ _____

Phone Number: Fax Number:

_____ _____

Patient signature: Date:

_____

Office use:

Patient account number _____

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PATIENT E-MAIL AND TEXT MESSAGING REGISTRATION FORM

We now have the ability to provide our patients with certain types of information via E-mail or text messaging. If you would like to receive this feature in the future, please read the consent below and sign.

Consent to Email and/or Text Message for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications/information at that email and/or text from Allergy Associates.

_____ (***Patient initials***) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is (_____)_____-_____Carrier:_____

_____ **(Patient initials)** I consent to emails, to receive communications as stated above. The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is,
_____.

_____ **I DO NOT WISH TO RECEIVE E-MAILS OR TEXT MESSAGES.**

-I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Print Patient Name:
_____DOB:_____
Patient/Parent or Guardian Signature:

_____Date:_____

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Evaluation and Treatment of Minors Consent

I, _____, the parent or legal guardian of _____ DOB _____ will allow Medical Appointments with Premier Allergist and consent to the treatment of my child.

The Consent is active:

_____Only on _____

_____From_____

_____Until cancelled by me in writing.

I maintain the right to cancel this consent at any time by writing to the Premier Allergist.

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of Witness Date

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New Patient History

Name: _____ **Date of Birth:** _____

Primary Care Physician:_____ **Referred by:** _____

Pharmacy: _____ **How did you hear about us?**_____

Reason for today's visit: _____

Current Medications(dose & frequency):

Medication Allergies/Sensitivities(list reaction):

Food Allergies/Sensitivities (list reaction):

Symptoms-*circle all that apply*

Ear, Nose, Throat: runny nose, sneezing, nasal congestion, post nasal drip, sore throat, sinus pressure/pain, throat swelling, ear aches

Eyes: itchy, watery, dry, red, swollen, drainage, dark circles, pain

Respiratory:cough, shortness of breath, wheezing, chest tightness

Skin symptoms: hives, itching, rash, dryness, eczema

Stomach: upset stomach, reflux, nausea, vomiting, diarrhea, constipation, abdominal pain

Head: migraines, chronic headaches, vertigo, dizziness

Past Allergy & Asthma History-*circle all that apply*

Previous skin tests/blood tests/allergy shots?

Vaccinations up to date? Yes/No Any adverse reactions to vaccinations?

Asthma diagnosis? Yes/No made how many years ago?_____ Last chest x-ray?_____ Results?

Use of an inhaler or nebulizer? Yes/No Performed a Pulmonary Function Test? Yes/No

Stung by a bee? Yes/No Any adverse reaction? Yes/No If yes, please describe reaction:

Medical History:

Emergency Room Visits *(date and reason):*

Days of school or work missed per year:

History of*(circle all that apply)*:

Cancer	Breast, Brain, Lung, Pancreatic, Ovarian, Prostate, Stomach, Liver, Skin, Cervical, Esophageal, Other:
Cardiac	Stroke, Hypertension, Palpitations, Murmur, Pacemaker
Eyes	Glasses, Contact lenses, Glaucoma, Blindness, Cataracts, Eye Disease
Ears	Hearing aids, Hearing loss, Chronic ear infections
Nose	Nasal polyps, Nosebleeds, Allergic rhinitis, Chronis sinusitis
Skin	Rash, Eczema, Acne, Hair loss, Nail disorders
Musculoskeletal	Arthritis, Osteoporosis, Chronic back pain
Endocrine	Diabetes, Thyroid condition, Autoimmune disorder, Kidney disease, Renal disease, Addison's disease, Scleroderma, Lupus
Gastrointestinal	Reflux, Esophagitis, Hernia, Ulcer, Polyps, Gallbladder, Crohn's Disease, Irritable Bowel Syndrome
Urinary/Reproductive	Breast Disease, Prostate Disease, Childbirth history
Respiratory	Asthma, COPD, Chronic bronchitis, Tuberculosis, Pneumonia, Emphysema, Sleep Apnea- on CPAP?
Neurological	Epilepsy, Seizures, Chronic headaches, Migraines, Memory loss, Stroke
Psych/Social	Depression, Suicide Attempt, Anxiety, Bipolar, OCD, Insomnia

Surgical History (list date & procedure):

Family History (check all that apply):

	Asthma	Allergies	Immune Disorder	Other (list)
Father				
Mother				
Brother				
Sister				
Paternal GF				
Paternal GM				
Maternal GF				
Maternal GM				

Social History:

Occupation: _____ Where Employed: _____

Hobbies: _____ Number of children: _____

Marital Status: Single, Married, Divorced, Separated, Widowed, Other

Primary Residence: One home; 2 or more homes

Tobacco Use: Yes/No How much for how long? _____ **Tobacco Exposure:** Yes/No

Alcohol Use: Yes/No **Drug Dependency:** Yes/No

Pets	Number	Age	How long owned	Kept where	Bathed?	Bedroom Access?	Symptoms
Cat							
Dog							
Bird							
Rabbit							
Hamster							
Guinea Pig							
Reptile							
Other							

Environmental History:

Type of Home: Single Family, Townhouse, Mobile Home, Apartment, Other

Structure: Wood Frame, Brick. Age:_____ Length of Residency: _____

Heat/Cooling System: Forced Hot Air, Central Air, Window Air Conditioners, Radiators

Foundation: Basement, Crawl Space, Slab Dehumidifier: Yes/No

Patient's Bedroom: Carpet, Hardwood, Tile, Curtains

Bedding: Feather Pillows, Foam Pillows, Standard Bed, Water Bed. Hypoallergenic Bedding: Yes/No

Plants: Number and location of plants_____

Laundry: Location of laundry room _____ Outdoor clothes line: Yes/No

Comments:

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Patient Name: _____ **DOB: _____**

Date of Service: _____

Skin testing is a procedure that involves scratch and intradermal testing with a vaccine solution prepared from allergens to which you may be sensitive.

It is always possible that an allergic reaction could follow this testing.

Reactions could be as follows:

- Skin irritation & itching

- Generalized itching or hives

- Wheezing

- Asthma

- Fainting

- Anaphylaxis

(rarely, death)

Although the above symptoms occur very infrequently, we feel the patient should be aware of the risks.

I acknowledge that I understand the above information and that my questions have been answered to my satisfaction.

Patient Signature (or parent/guardian): _____

Witness: _____