Bless You Allergy & Asthma, P.A.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name First MI	Nickname		Male / Female	Date of Birth
If Patient is under 18 – Legal Guardian Name		Phone #		
Permanent Address	City		State	Zip
Main Phone #: (please circle one) Cell Home Business	Secondary Phone #: Cell Home Business		Email	
Race	Ethnicity			
Occupation	Work Phone #			
Primary Care Physician	Location		Phone #	
Referring Physician	Location		Phone #	
Emergency Contact	Relationship		Phone #	
Pharmacy Name	Location		Phone #	

Who can we thank for referring you? _____

INSURANCE

Primary Insurance Company Name		
Policy Holder Name	DOB	Relation to Patient
Policy #	Group #	Effective Date
Secondary Insurance Company Name		
Policy Holder Name	DOB	Relation to Patient
Policy #	Group #	Effective Date

I hereby authorize Bless You Allergy & Asthma, P.A. to treat the person named above and agree to pay all fees and charges for such treatment. I also authorize the release of information acquired during the course of the examination or treatment to the referring physician, my primary care doctor or to an appropriate insurance carrier.

If a Medicare patient, I further authorize release to the Center of Medicare Services and its agents any information needed to determine benefits payable for related charges.

As a present or future member of a Health Maintenance Organization (HMO) or other third party payer. I recognize that I may be required by my insurance to get Primary Care Physician's referral prior to being treated. If I do not obtain a referral I understand that I am circumventing my health care plan and may be required to pay for services rendered. In such cases, I agree to accept full financial responsibility for charges related to the services rendered without a referral.

Signature: _____ Relationship to Patient ☐ Self ☐ Parent ☐ Guardian Date: _____

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PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____

REGULAR MEDICATION INFORMATION

Please list below ALL prescribed medications/vitamin supplements/over the counter medications that you take on a REGULAR/DAILY basis

Medication/Vitamin/Over Counter Medication	Medication Strength (mg/mcg)	Dosage Information (daily, 3x day)

RECENT OTHER MEDICATION

Please list below ALL prescribed medications/vitamin supplements/over the counter medications that you have taken THIS WEEK that IS DIFFERENT from the above list (antibiotics, antihistamines, cold/flu medications)

Medication/Vitamin/Over Counter Medication	Medication Strength (mg/mcg)	Dosage Information (3x day)
How long have you been taking this?	When was the last time you took this?	
Medication/Vitamin/Over Counter Medication	Medication Strength (mg/mcg)	Dosage Information (3x day)
How long have you been taking this?	When was the last time you took this?	
Medication/Vitamin/Over Counter Medication	Medication Strength (mg/mcg)	Dosage Information (3x day)
How long have you been taking this?	When was the last time you took this?	

INTOLERANCE

Please list all medications you are allergic to or intolerant of	Reaction	Date

INTOLERANCE

Please list all FOODS you do not tolerate	Reaction	Date

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PATIENT MEDICAL HISTORY

Patient Name _____ Date of Birth _____

Do you have any history of the following medical conditions in yourself or in your BLOOD RELATIVES?

FAMILY HISTORY

Hay Fever (allergic rhinitis)	☐ self ☐ mom ☐ dad other _____	Bleeding Disorder	☐ self ☐ mom ☐ dad other _____
Asthma	☐ self ☐ mom ☐ dad other _____	High Blood Pressure	☐ self ☐ mom ☐ dad other _____
Eczema	☐ self ☐ mom ☐ dad other _____	Heart Disease	☐ self ☐ mom ☐ dad other _____
Hives	☐ self ☐ mom ☐ dad other _____	Arthritis	☐ self ☐ mom ☐ dad other _____
Nasal Polyps	☐ self ☐ mom ☐ dad other _____	Diabetes	☐ self ☐ mom ☐ dad other _____
Bee/Wasp/Hornet/Fire Ant Allergy	☐ self ☐ mom ☐ dad other _____	Stroke	☐ self ☐ mom ☐ dad other _____
		Seizure Disorder	☐ self ☐ mom ☐ dad other _____
Cystic Fibrosis	☐ self ☐ mom ☐ dad other _____	Thyroid Disease	☐ self ☐ mom ☐ dad other _____
Food Allergies	☐ self ☐ mom ☐ dad other _____	Autoimmune Disease (Lupus, Rheumatoid Arthritis) or Arthritis)	☐ self ☐ mom ☐ dad other _____
Cancer (type)	☐ self ☐ mom ☐ dad other _____ _____	Migraines	☐ self ☐ mom ☐ dad other _____
Chronic Sinus Problems	☐ self ☐ mom ☐ dad other _____	COPD	☐ self ☐ mom ☐ dad other _____

SURGICAL

Ear Tubes	☐ Yes ☐ No Date: _____	Appendix Removal	☐ Yes ☐ No Date: _____
Sinus Surgery	☐ Yes ☐ No Date: _____	Gall Bladder Removal	☐ Yes ☐ No Date: _____
Tonsillectomy/ Adenoidectomy	☐ Yes ☐ No Date: _____	Hip/Knee/Back Surgery	☐ Yes ☐ No Date: _____
Hysterectomy	☐ Yes ☐ No Date: _____	Other Surgeries/Hospitalizations Type and Date:	
C-Section	☐ Yes ☐ No Date: _____		
Eye Surgery	☐ Yes ☐ No Date: _____		

SOCIAL

Do you use or have you used Tobacco? ☐ Yes ☐ No Recreational Drugs? ☐ Yes ☐ No

Alcohol Use: _____ # per day, _____ # per week, ☐ none/less than 4 per week

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of Children:

Spouse's Name: | Is your child in daycare? ☐ Yes ☐ No

Adult Occupation: ☐ Student | Were you adopted? ☐ Yes ☐ No

Are your Immunizations up to date? ☐ Yes ☐ No | Have you had a previous allergy evaluation/testing? ☐ Yes ☐ No

Testing Date	Doctor Name	City	Result

Do you take allergy or sublingual immunotherapy injections? ☐ Yes ☐ No | Have you ever needed an Epi-pen? ☐ Yes ☐ No

If yes, how long have you been taking them? | Do they help? ☐ Yes ☐ No

Have you had any reactions to the shots? ☐ Yes ☐ No | Was it a ☐ Local or ☐ Systemic reaction?

ENVIRONMENTAL

How long have you lived in this area? Where did you live before?

What TYPE of housing do you live in? ☐ House ☐ Condo/Townhome ☐ Modular/Mobile Home ☐ Apartment

How LONG have you lived in the above housing? | Does your house/workplace have a moldy/musty smell? ☐ Yes ☐ No

What TYPE of heating does your home have? ☐ Forced Hot Air ☐ Radiant | Source: ☐ Gas ☐ Electric ☐ Oil Other:

What TYPE of cooling system? ☐ Central ☐ Window Unit | Do you have Plants? ☐ Yes ☐ No If yes, ☐ Live ☐ Synthetic

What TYPE of flooring is in your home and where is it?
Carpet: ☐ Bedroom ☐ Living space ☐ Whole House ☐ None
Tile: ☐ Bedroom ☐ Living space ☐ Whole House ☐ None
Laminate: ☐ Bedroom ☐ Living space ☐ Whole House ☐ None
Hardwood: ☐ Bedroom ☐ Living space ☐ Whole House ☐ None
Are there smokers who live in the house? ☐ Yes ☐ No

Type of Filters used in the House: ☐ Standard ☐ HEPA ☐ Electronic ☐ Electrostatic

Pets? ☐ Dog ☐ Cat ☐ Bird ☐ Reptile ☐ Mouse/Rat ☐ Guinea Pig ☐ Horse ☐ Other:

Are these items in your house? (check all that apply) ☐ Ceiling Fans ☐ Humidifier ☐ Stuffed Animals ☐ Down Pillows/Comforters

What type of pillow do you use? ☐ Cotton ☐ Feather/Down ☐ Foam | Have you "allergy proofed" your bed? ☐ Yes ☐ No

Patient Name: _____ Today's Date: _____

	Review of System		Comments		Review of System		Comments
General	Chills	☐ Yes ☐ No		Pulmonary	Chest Tightness	☐ Yes ☐ No	
	Difficulty Sleeping	☐ Yes ☐ No			Cough	☐ Yes ☐ No	
	Fatigue	☐ Yes ☐ No			Shortness of Breath	☐ Yes ☐ No	
	Fever	☐ Yes ☐ No			Sputum/Mucous	☐ Yes ☐ No	☐ Clear ☐ Colored
	Sweats	☐ Yes ☐ No			Wheezing	☐ Yes ☐ No	
	Weight Gain/Loss	☐ Yes ☐ No					
Eyes	Blurred Vision	☐ Yes ☐ No		Cardio/Vas	High Blood Pressure	☐ Yes ☐ No	
	Eyes Discharge	☐ Yes ☐ No			Chest Pain	☐ Yes ☐ No	
	Eyes Itching	☐ Yes ☐ No			Difficulty Lying Flat	☐ Yes ☐ No	
	Eyes Redness	☐ Yes ☐ No			Palpitations	☐ Yes ☐ No	
	Eyes Swelling	☐ Yes ☐ No			Swelling in hands/feet	☐ Yes ☐ No	
	Glasses/Contacts	☐ Yes ☐ No					
Ears	Ear Drainage	☐ Yes ☐ No	☐ Clear ☐ Colored	GI	Abdominal Pain	☐ Yes ☐ No	
	Ear Infection	☐ Yes ☐ No			Change in Appetite	☐ Yes ☐ No	
	Ear Pain	☐ Yes ☐ No			Constipation	☐ Yes ☐ No	
	Ear Swelling	☐ Yes ☐ No			Diarrhea	☐ Yes ☐ No	
	Ear Tubes	☐ Yes ☐ No			Indigestion/Heartburn	☐ Yes ☐ No	
	Hearing Loss	☐ Yes ☐ No			Nausea	☐ Yes ☐ No	
	Ringing in the Ears	☐ Yes ☐ No			Sour Taste	☐ Yes ☐ No	
					Vomiting	☐ Yes ☐ No	
Nose	Drainage - Nose	☐ Yes ☐ No	☐ Clear ☐ Colored	Skin	Acne	☐ Yes ☐ No	
	Drainage - Throat (Post Nasal Drip)	☐ Yes ☐ No	☐ Clear ☐ Colored		Flushing of Skin	☐ Yes ☐ No	
	Nasal Congestion	☐ Yes ☐ No			Hives	☐ Yes ☐ No	
	Nasal Itching	☐ Yes ☐ No			Moles	☐ Yes ☐ No	
	Nasal Polyps	☐ Yes ☐ No			Rash	☐ Yes ☐ No	
	Nose Bleeds	☐ Yes ☐ No			Scaly Skin	☐ Yes ☐ No	
	Sneezing	☐ Yes ☐ No			Skin Dryness	☐ Yes ☐ No	
	Snoring	☐ Yes ☐ No			Skin Itching	☐ Yes ☐ No	
Throat	Difficulty Swallowing	☐ Yes ☐ No		Endocrin	Cold/Heat Intolerant	☐ Yes ☐ No	
	Hoarseness	☐ Yes ☐ No			Diabetes	☐ Yes ☐ No	
	Pauses in Breath/Sleep Apnea	☐ Yes ☐ No			Excessive Thirst	☐ Yes ☐ No	
	Sore Throat	☐ Yes ☐ No			Thyroid Problems	☐ Yes ☐ No	
	Throat Itching	☐ Yes ☐ No		Immun			
	Throat Swelling	☐ Yes ☐ No			Have you had a Flu Shot this Year*?	☐ Yes ☐ No	*Aug. 2016-March 2017
	Tongue Swelling	☐ Yes ☐ No					
Psych	Agitation	☐ Yes ☐ No		Neurological	Dizziness	☐ Yes ☐ No	
	Anxiety	☐ Yes ☐ No			Double Vision	☐ Yes ☐ No	
	Depression	☐ Yes ☐ No			Migraines	☐ Yes ☐ No	
	Moodiness	☐ Yes ☐ No			Numbness	☐ Yes ☐ No	
	Nervousness	☐ Yes ☐ No			Tension Headaches	☐ Yes ☐ No	
	Panic	☐ Yes ☐ No			Tingling	☐ Yes ☐ No	
	Stress	☐ Yes ☐ No			Weakness	☐ Yes ☐ No	
Heme	Anemia	☐ Yes ☐ No		Mus/Ske	Back Pain	☐ Yes ☐ No	
	Blood Clots	☐ Yes ☐ No			Joint Pain	☐ Yes ☐ No	
	Easy Bruising/Bleeding	☐ Yes ☐ No			Muscle Pain	☐ Yes ☐ No	
	Slow to Heal Cuts	☐ Yes ☐ No			Muscle Weakness	☐ Yes ☐ No	
	Swollen Glands	☐ Yes ☐ No			Swollen Joints	☐ Yes ☐ No	

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Patient Name _____ Date of Birth_____

Medical Records Release

I understand that my protected health information may be requested from any healthcare provider within the past 10 years who may be involved in my health treatment, and that this information may be used to conduct, plan and direct my treatment and follow-up among multiple health care providers

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

By signing below, I permit Bless You Allergy & Asthma, P.A. (BYAA) to obtain medical records (including hospital and physician progress notes; radiology and imaging reports; laboratory and pathology reports; and any additional medical data) required for my treatment at BYAA.

Patient/Guardian Signature:_____ Date:_____

It is often helpful if our office sends your office notes, lab results, imaging reports, testing results, etc., to your primary care physician and referral physicians. I also authorize Dr. George Browne and his nurses to discuss any of my medical conditions with my primary care referral physicians.

Patient/Guardian Signature:_____Date:_____

FINANCIAL AGREEMENT

Please read the following Financial Policy and sign below:

Bless You Allergy & Asthma asks that patients arrange for payment for all billed services at the time of service. This helps to reduce administrative costs, and keeps your health care affordable.

This office is contracted with numerous insurance companies and will file your claim as a courtesy to you. As every plan has different stipulations regarding payment for services received, **it is your responsibility to understand your benefits.** Please inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment, as you will be billed directly if your insurance company does not cover these charges. This policy also applies in the event of claim refutations, such as medical necessity or pre-existing condition denials.

Please know that you will be made aware of any outstanding balance on your account through statements in the mail and emails. However, after 90 days of nonpayment your case will be sent to our collections agency.

By signing this financial agreement, you, the patient, are ultimately responsible for payment on your account. If you have any questions regarding the financial policy of this office, please ask us.

Patient/Guardian Signature _____ Date _____