



# PATIENT REGISTRATION FORM

<b>PATIENT INFORMATION</b>	Patient's Last Name	First	MI	Nickname	Male	Date of Birth	
					Female		
	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			
	Employer			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? \_\_\_\_\_

<b>INSURANCE</b>	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: \_\_\_\_\_

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

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

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

<b>SURGICAL</b>	Ear Tubes	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	Appendix Removal	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
	Sinus Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	Gall Bladder Removal	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
	Tonsillectomy/Adenoidectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	Hip/Knee/Back Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
	Hysterectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	Other Surgeries/Hospitalizations Type and Date: _____	
	C-Section	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____		
	Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____		

<b>SOCIAL</b>	Do you use or have you used Tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No		Recreational Drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Alcohol Use: _____ # per day, _____ # per week, <input type="checkbox"/> none/less than 4 per week			
	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Number of Children: _____	
	Spouse's Name: _____		Is your child in daycare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Adult Occupation: _____ <input type="checkbox"/> Student		Were you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are your Immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you had a previous allergy evaluation/testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Testing Date	Doctor Name	City	Result
	Do you take allergy or sublingual immunotherapy injections? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you ever needed an Epi-pen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, how long have you been taking them? _____		Do they help? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any reactions to the shots? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was it a <input type="checkbox"/> Local or <input type="checkbox"/> Systemic reaction?		

<b>ENVIRONMENTAL</b>	How long have you lived in this area? _____		Where did you live before? _____	
	What TYPE of housing do you live in? <input type="checkbox"/> House <input type="checkbox"/> Condo/Townhome <input type="checkbox"/> Modular/Mobile Home <input type="checkbox"/> Apartment			
	How LONG have you lived in the above housing? _____		Does your house/workplace have a moldy/musty smell? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	What TYPE of heating does your home have? <input type="checkbox"/> Forced Hot Air <input type="checkbox"/> Radiant		Source: <input type="checkbox"/> Gas <input type="checkbox"/> Electric <input type="checkbox"/> Oil Other: _____	
	What TYPE of cooling system? <input type="checkbox"/> Central <input type="checkbox"/> Window Unit		Do you have Plants? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Live <input type="checkbox"/> Synthetic	
	What TYPE of flooring is in your home and where is it?		Carpet: <input type="checkbox"/> Bedroom <input type="checkbox"/> Living space <input type="checkbox"/> Whole House <input type="checkbox"/> None	
	Tile: <input type="checkbox"/> Bedroom <input type="checkbox"/> Living space <input type="checkbox"/> Whole House <input type="checkbox"/> None		Laminate: <input type="checkbox"/> Bedroom <input type="checkbox"/> Living space <input type="checkbox"/> Whole House <input type="checkbox"/> None	
	Hardwood: <input type="checkbox"/> Bedroom <input type="checkbox"/> Living space <input type="checkbox"/> Whole House <input type="checkbox"/> None		Are there smokers who live in the house? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Type of Filters used in the House: <input type="checkbox"/> Standard <input type="checkbox"/> HEPA <input type="checkbox"/> Electronic <input type="checkbox"/> Electrostatic			
	Pets? <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Bird <input type="checkbox"/> Reptile <input type="checkbox"/> Mouse/Rat <input type="checkbox"/> Guinea Pig <input type="checkbox"/> Horse <input type="checkbox"/> Other: _____			
	Are these items in your house? (check all that apply) <input type="checkbox"/> Ceiling Fans <input type="checkbox"/> Humidifier <input type="checkbox"/> Stuffed Animals <input type="checkbox"/> Down Pillows/Comforters			
	What type of pillow do you use? <input type="checkbox"/> Cotton <input type="checkbox"/> Feather/Down <input type="checkbox"/> Foam		Have you "allergy proofed" your bed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

		REVIEW OF SYSTEM	COMMENTS			REVIEW OF SYSTEM	COMMENTS
GENERAL	Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No		PULMONARY	Chest Tightness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Difficulty Sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No			Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No			Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No			Sputum/Mucous	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Clear <input type="checkbox"/> Colored
	Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No			Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Weight Gain/Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No					
EYES	Blurred Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No		CARDIO/VAS	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Eyes Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No			Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Eyes Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No			Difficulty Lying Flat	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Eyes Redness	<input type="checkbox"/> Yes <input type="checkbox"/> No			Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Eyes Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No			Swelling in hands/feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Glasses/Contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No					
EARS	Ear Drainage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Clear <input type="checkbox"/> Colored	GI	Abdominal Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ear Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No			Change in Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ear Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No			Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ear Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No			Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ear Tubes	<input type="checkbox"/> Yes <input type="checkbox"/> No			Indigestion/Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No			Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ringing in the Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No			Sour Taste	<input type="checkbox"/> Yes <input type="checkbox"/> No	
NOSE	Drainage - Nose	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Clear <input type="checkbox"/> Colored	SKIN	Acne	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Drainage - Throat (Post Nasal Drip)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Clear <input type="checkbox"/> Colored		Flushing of Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Nasal Congestion	<input type="checkbox"/> Yes <input type="checkbox"/> No			Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Nasal Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No			Moles	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Nasal Polyps	<input type="checkbox"/> Yes <input type="checkbox"/> No			Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Nose Bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No			Scaly Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Sneezing	<input type="checkbox"/> Yes <input type="checkbox"/> No			Skin Dryness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No			Skin Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No	
THROAT	Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No		ENDOCRINE	Cold/Heat Intolerant	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Hoarseness	<input type="checkbox"/> Yes <input type="checkbox"/> No			Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Pauses in Breath/Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No			Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No			Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Throat Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	Throat Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No			Has patient had a flu shot this year**?	<input type="checkbox"/> Yes <input type="checkbox"/> No	**Flu Season from August to March
	Tongue Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No					
PSYCH	Agitation	<input type="checkbox"/> Yes <input type="checkbox"/> No		NEUROLOGICAL	Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No			Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No			Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Moodiness	<input type="checkbox"/> Yes <input type="checkbox"/> No			Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Nervousness	<input type="checkbox"/> Yes <input type="checkbox"/> No			Tension Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Panic	<input type="checkbox"/> Yes <input type="checkbox"/> No			Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Stress	<input type="checkbox"/> Yes <input type="checkbox"/> No			Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
HEME	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No		MUS/SKEL	Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No			Joint Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Easy Bruising/Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No			Muscle Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Slow to Heal Cuts	<input type="checkbox"/> Yes <input type="checkbox"/> No			Muscle Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Swollen Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No			Swollen Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	



# Bless You Allergy & Asthma

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 (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 my Child's Primary Care Doctor and Nurses to discuss any of my medical conditions with my primary care and 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 \_\_\_\_\_