DALLAS ALLERGY & ASTHMA CENTER

GARY N. GROSS, M.D.
MICHAEL E. RUFF, M.D.
DANIA A. WIERZBICKI, M.D.
LARA M. GROSS, M.D.

Date _____

Patient's Last Name _____ **First Name** _____ **Middle Initial** _____

Address _____ City _____ State _____ Zip _____

Sex _____ Date of Birth _____ Age_____ Home Phone _____ Cell Phone _____

Social Security # _____ Drivers License _____ Email _____

Employer_____ Address_____ Work Phone _____

Pharmacy_____ Address_____ Phone_____

Name of Responsible Party (if other than patient):
Name _____ Relationship _____ Phone _____
Address _____ City _____ State _____ Zip _____
Emergency Contact Name _____ Relationship_____ Phone _____

Please list other members of your family that are patients here and their relationship:
_____

Referred by _____

Primary Care Physician _____ Phone _____

PRIMARY Insurance Company _____ Insured Name _____

Date of Birth of Insured_____ Sex _____ Relationship to patient _____ Phone _____

Member ID # _____ Group # _____ Customer Service Phone # _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I understand that I am required to give my current insurance card, driver's license, and any other billing information for statements and insurance to be filed on my behalf. I understand that I will notify Dallas Allergy & Asthma Center of any changes in my insurance or billing information. If this is not done, I will be responsible for all charges incurred because of timely filing required by my insurance. I am also responsible for services denied by my insurance company as "non-covered" or not "medically necessary." I authorize treatment of the person named above and agree to pay all reasonable fees for such treatment. It is agreed that I am responsible for all payments/co-pays/co-insurance/deductibles at the time service is rendered regardless of insurance coverage eligibility. I authorize the release of any medical information necessary to process insurance claims.

Signature X_____ Date _____

Signature X_____ Date _____

In my absence, I _____ hereby give consent to _____
Parent/Legal Guardian — Person accompanying minor

to accompany _____to Dallas Allergy & Asthma Center for his/her visit.
Name of Minor

Signature of parent or guardian X_____ Date _____

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PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF PERSONAL HEALTH INFORMATION

I understand that as part of my healthcare, Dallas Allergy & Asthma Center (DAAC) originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations.

Dallas Allergy & Asthma Center *Notice of Privacy Practices* provides specific information and complete description of how my personal health information (PHI) may be used and disclosed. I have been provided a copy of the *Notice of Privacy Practices,* effective April 14, 2003 and understand that I have the right to review the notice prior to signing this authorization. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that Dallas Allergy & Asthma Center is not required to agree to the restrictions requested. I may revoke this authorization at any time in writing except to the extent that Dallas Allergy & Asthma Center has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

Please list family members or other persons, if any, whom may inquire and/or be informed about your general medical concerns/condition/diagnosis:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Other restrictions on the use/or disclosure of my personal health information:

_____

_____

_____	_____	_____
Signature of Patient/Guardian	Date	Witness
_____	_____	_____
Print Patient Name/Guardian	Date	Print Name of Witness

DAAC may use my personal health information to screen for research studies (Drs. Gross, Ruff and Wierzbicki).

_____	_____
Signature of Patient/Guardian	Date

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FINANCIAL POLICY

Thank you for choosing our practice as your healthcare provider. Your clear understanding of our Financial Policy is important to our professional relationship. Please speak with the receptionist if you have any questions regarding this policy.

ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED

Payment is required at the time services are rendered. Such payments include co-pays/co-insurance/deductibles and non-covered services for participating insurance companies. We accept cash, personal checks, Visa, Master Card and Discover. There is a $35 service charge on all returned checks. If the patient is a minor, the parent/guardian is the responsible party.

INSURANCE

If we are contracted with your insurance company, we will file your charges for you. It is your responsibility to know your insurance plan benefits and its provisions. ***We cannot guarantee payment of your claims as insurance companies only "quote" benefits, they never "guarantee" benefits***. It is your responsibility to make sure we have your current insurance information so that we may correctly file your claims in a timely manner as the insurance companies have timely filing limitations. You will be required to show your insurance card at every visit for filing purposes**.** If we are not contracted with your insurance company, you will be required to pay in full at the time services are rendered.

REFERRALS

If you are on an insurance plan that requires a referral, it is your responsibility to obtain a referral for your visits. The referral must be requested from your primary care physician **prior** to your appointment in order for your claim to be filed appropriately.

MINORS

The guardian, who brings the minor in for the appointment, is responsible for payment (i.e. co-pays/co-insurance/deductibles and non-covered services) for the services that are rendered. In divorce situations, please provide a copy of the judge appointed decree so that we will bill the appropriate responsible party. *Per the Privacy Act (HIPAA), all mail must be addressed to patients age 18 and older, regardless of guarantor/insured/responsible party.*

BILLING

If you have any questions in regards to any of your billing statements and/or insurance claims, our billing staff is available to assist you.

I have read and understand Dallas Allergy & Asthma Center's Financial Policy. I agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Patient Name: _____

Signature of Responsible Party: _____

Date: _____

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OFFICE POLICY

Thank you for choosing our practice as your healthcare provider. Your clear understanding of our Office Policy is important to our professional relationship. Please speak with the receptionist if you have any questions regarding this policy.

APPOINTMENTS

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment.

CANCELLATION/NO SHOW POLICY

Patients who do not cancel or reschedule their appointment at least 24 hours prior to their scheduled visit may be charged a $50.00 fee. Also, this fee applies to any patient who does not show up for their scheduled appointment. The confirmation of your appointment is a courtesy provided by our office, however we will make reasonable attempts to confirm your appointment.

It remains the patient's responsibility to keep or reschedule appointments in compliance with the above policy. *Exceptions will be made for medical or family emergencies.* Please note that insurance companies cannot be billed for missed appointments therefore it is the patient's responsibility.

FORMS/PRESCRIPTIONS

School/Camp/Physical forms may be mailed, faxed or dropped off at our office. We require a 1 week notice for completion and will be happy to mail, fax or hold them for you to pick up. For written prescriptions, please allow 24 hours for completion.

MEDICAL RECORDS

We are dedicated to keeping your medical records confidential and therefore require written authorization for the release of your medical records. Medical records will be completed within 15 business days as mandated by the Texas Board of Medical Examiners and may be subject to a processing fee as determined by the Board. A $25 FEE WILL BE ASSESSED FOR COPIES REQUESTED FOR PERSONAL MATTERS (i.e. personal copy, life insurance policy and attorney requests)

CONVENTIONAL IMMUNOTHERAPY/RUSH IMMUNOTHERAPY

All patients receiving allergy injections must wait in the waiting room **at least ` 30 minutes** following each injection. We do ask that you pay your co-pay/co-insurance/deductible portion when you receive your injection. When a new vial of serum needs to be made, we do require you to clear any balance before processing the vial. A written request and signature from the patient is required prior to the mixing of all vials.

I have read and understand Dallas Allergy & Asthma Center's Office Policy. I also understand that I will be responsible for the fee charged regarding the above Cancellation/No Show Policy.

Patient Name: _____

Signature of Responsible Party: _____
Date: _____

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NAME_____ **Date**_____

In order to assess your symptoms, please answer the following questions to the best of your knowledge. This sheet will be reviewed during your visit with the doctor.

What is your primary reason for visiting our office? _____
_____

What is your goal for this visit? _____
_____

CURRENT SYMPTOMS

1) Nasal (if you do not have these symptoms, please skip to #2)

a. When did your nasal symptoms first begin?
_____

b. Drainage……Yes No
Clear / White / Yellow / Green
Thick / Thin

c. Congestion…..Yes No
Is one side worse than the other? _____

d. Sneezing……..Yes No
Rarely / Often / Continuously / In attacks

e. Nasal Itching……Yes No

f. Do you get sinus infections?.....Yes No
How many per year? _____
When was your most recent infection? _____
Were you given an antibiotic? _____

g. Are your nasal symptoms seasonal / year-round?
If seasonal, when? Summer / Fall / Winter / Spring
If year-round, are some seasons worse than others?
Summer / Fall / Winter / Spring

h. Does anything make your nasal symptoms worse? (e.g. indoors vs. outdoors, traveling, animals, smoke, dust, mowed grass, odors, perfumes, household cleaners, etc.). _____
_____

i. What makes your nasal symptoms better? (e.g. steam, medication, travel, etc.). _____
_____

2) Eyes (if you do not have these symptoms, please skip to #3)

a. Itching……Yes No
b. Watering…Yes No
c. Redness…Yes No
d. Swelling….Yes No

e. Vision problems…Yes No
Please describe. _____

f. Do you have an eye doctor? Have you seen them for the above problem(s)?
_____

g. What makes your eye symptoms worse? _____

h. What makes your eye symptoms better? _____

3) Ears (if you do not have these symptoms, please skip to #4)

a. Do you have problems with your ears?.....Yes No
If yes, please describe (e.g. popping, ringing, pain, pressure, itching, etc.).
_____

b. Do you have frequent ear infections or did you have them as a child?.....Yes No
When was your most recent infection? _____

c. Have you ever had tubes put in your ears?.....Yes No
If yes, when? _____

4) Mouth/Throat (if you do not have these symptoms, please skip to #5)

a. Itching in the roof of your mouth?.....Yes No
b. Itching in your throat……..Yes No
c. Frequent sore throats?.....Yes No
d. Drainage in your throat?.....Yes No
e. Do you clear your throat often?.....Yes No
f. Hoarseness?.....Yes No

5) Head (if you do not have these symptoms, please skip to #6)

a. Do you have frequent headaches?.....Yes No
Where are they located? _____
How often do they occur? _____

b. Have you ever been diagnosed with migraine and/or tension headaches?.....Yes No
Which one (or both)? _____ When were you diagnosed? _____

c. What makes your headaches worse? (e.g. sinus congestion, noise, foods, etc.).
_____

d. What makes your headaches better? (e.g. medication, rest, foods, etc.).
_____

6) Skin (if you do not have these symptoms, please skip to #7)

a. Eczema?.....Yes No
Where? _____
What makes it worse/better? _____

b. Hives/urticaria?.....Yes No
Where? _____
What makes them worse/better? _____

c. Rashes?.....Yes No
Where? _____

7) Chest (if you do not have these symptoms, please skip to the next section)

a. When did your chest symptoms start? _____
b. Cough……..…Yes No
Please Describe._____
c. Wheezing……...Yes No
d. Chest tightness……..Yes No
e. Shortness of breath…Yes No
f. What makes your chest symptoms worse? (e.g. exercise, cold, heat, stress, etc.).
_____

g. What makes your chest symptoms better? (e.g. medication, rest, etc.).
_____

h. Have you ever been diagnosed with asthma?.....Yes No
When? _____ By Whom? _____
What asthma medications have you been on? _____
_____

i. Do you have a rescue inhaler? (e.g. albuterol, Proventil, Xopenex, Maxair). .....Yes No
How often do you use it? _____ Do you ever wake up to use it? How often? _____

j. Have you ever been to an emergency room for you asthma?.....Yes No
When/Where? _____

k. Have you ever been hospitalized due to asthma?.....Yes No
When/Where? _____

PREVIOUS EVALUATION

1) Have you ever seen another doctor (including your primary care doctor) for the above symptoms? Who?
_____
2) What treatments have you tried for your symptoms? (please include both prescription and over-the-counter).
_____
_____
3) Have you ever been tested for allergies?.....Yes No
By whom? _____ When? _____
What were you allergic to? _____
Were you put on allergy shots? When? _____
For how long? _____
4) Have you ever had an X-ray or CT scan of your sinuses?.....Yes No
When? _____ What were the results? _____
5) Have you ever had a chest X-ray?.....Yes No
When? _____ What were the results? _____

ENVIRONMENT

1) How long have you lived in the Dallas area? _____
2) Where did you live previously? _____
3) How long have you lived in your current residence? _____ How old is your current residence? _____
4) What type of foundation do you have (e.g.pier & beam, concrete slab)? _____
4) Do you have carpeting in your home?.....Yes No How old is your carpet? _____
5) How old is your mattress? _____
6) What type of pillows do you sleep on? _____ How old are they? _____
7) Do you have encasings (other than the pillow case) on your pillows or mattress?.....Yes No
8) Do you have any indoor pets?.....Yes No
What kind/How many? _____
How long have you had your pet(s)? _____

PAST MEDICAL HISTORY

1) What medical problems/conditions have you been diagnosed with or are you being treated for? _____
_____
_____

2) What medications are you currently taking? (please include over-the-counter medications as well).

Medication	Dosage	Frequency

3) Are you allergic to any medications? If so, please tell us which medication and what kind of reaction you have.
_____
_____

4) Please list any hospitalizations (when/where/why)? _____
_____
_____
_____

5) Please list any surgeries (when/what type)? _____
_____
_____
_____

6) Have you ever had an allergic reaction to any foods (e.g. peanuts, eggs, shellfish, etc.) If so, when? What type of reaction did you have? _____
_____

7) Have you ever had an unusual reaction to an insect bite or sting (e.g. anaphylaxis)? If so, when? What type of reaction did you have? _____
_____

6) Does anybody in your family have allergies or asthma? Who? _____
_____

SOCIAL HISTORY

1) What is your occupation? _____

2) Are you exposed to anything at work which worsens your symptoms? _____

3) Do you exercise?.....Yes No
What type of exercise/How often? _____

4) Do you have any children or do you work with young children?.....Yes No
What ages? _____

5) Do you currently (or have you ever) used tobacco products?.....Yes No
What type/for how long? _____
How much do you use? _____

REVIEW OF SYMTOMS

Are you **CURRENTLY** experiencing any of the following:

General:		**Skin:**		**Head / Neck:**	
Weight change	Y / N	Rash	Y / N	Swelling	Y / N
Fatigue	Y / N	Itching	Y / N	Pain	Y / N
Night Sweats	Y / N	Hair / Nail Changes	Y / N	Sinus Pressure	Y / N
Trouble sleeping	Y / N			Post nasal drip	Y / N
Mouth / Throat:		**Eyes:**		**Nose:**	
Sore	Y / N	Double vision	Y/ N	Congestion	Y / N
Lesions	Y / N	Blurred vision	Y/ N	Runny nose	Y / N
Swelling	Y / N	Itching	Y/ N	Bleeding	Y / N
Voice changes	Y / N	Watery	Y/ N	Reduced sense of smell	Y / N
Throat tightness	Y / N	Red	Y/ N	Itching	Y / N
Ears:		**Pulmonary:**		**Musculoskeletal:**	
Popping	Y / N	Cough	Y / N	Joint aches	Y / N
Ringing	Y / N	Chest tightness	Y / N	Joint swelling	Y / N
Decreased hearing	Y / N	Wheezing	Y / N	Muscle aches	Y / N
		Shortness of breath	Y / N	Stiffness	Y / N
Genitourinary:		**Gastrointestinal:**		**Cardiovascular:**	
Pain with urination	Y / N	Trouble swallowing	Y / N	Chest pain	Y / N
Blood in urine	Y / N	Heartburn	Y / N	Chest tightness	Y / N
Urinary frequency	Y / N	Nausea	Y / N	Palpitations	Y / N
Urinary urgency	Y / N	Vomiting	Y / N	Lower extremity swelling	Y / N
		Bloating	Y / N		
		Diarrhea	Y / N		
Neurologic:					
Headaches	Y / N	Current smoker	Y / N		
Light headedness	Y / N	Flu shot this season	Y / N		
Dizziness	Y / N				