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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 \_\_\_\_\_

**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  \_\_\_\_\_ Date \_\_\_\_\_

Signature  \_\_\_\_\_ 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  \_\_\_\_\_ Date \_\_\_\_\_



**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



## ***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***

All billing, claims and insurance filing is handled by Health Care Strategies. Health Care Strategies will mail statements directly to you. Should you have any questions regarding your statement or claim, you may contact them at (972) 701-8826, ext. 145.

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: \_\_\_\_\_



## ***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 \$20.00 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: \_\_\_\_\_



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?  
\_\_\_\_\_

e. Nasal Itching.....Yes No

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

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

c. Congestion.....Yes No  
Is one side worse than the other? \_\_\_\_\_

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

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

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

c. Redness...Yes No

b. Watering...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 | d. Drainage in your throat?.....Yes No        |
| b. Itching in your throat.....Yes No             | e. Do you clear your throat often?.....Yes No |
| c. Frequent sore throats?.....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? \_\_\_\_\_

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## 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? \_\_\_\_\_

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## 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**

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- 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**

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- 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 SYMPTOMS

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

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