ASTHMA & ALLERGY CENTER
Parkersburg. Ripley.Beckley.Logan.
CHARLESTON . WV 25314
Asthmaweb.com
304.343.4300

Welcome

All of us at the Asthma and Allergy Center would like to welcome you as a new patient to our office. Please read the Office Policies Brochure, fill in all six pages of the New Patient Registration & Medical History Form, and bring it with you on your first visit. If you have received this packet in mail and prefer to fill the form on a computer, you'll find it on the New Patient Page of our website: **asthmaweb.com**. Please print the filled form and bring it with you*.

You will need to stop taking any medications that contain antihistamines [such as Claritin, Benadryl, Clarinex, Zyrtec etc.] for a minimum of five days prior to your visit. If your appointment is less than five days away, or you cannot stop the Antihistamines due to severe symptoms, or you are not sure whether the medications you are taking contain anAntihistamine **, please call us. You must not stop any other medications you are on that do not contain antihistamines.

Please note that a new patient office visit can take up to three hours depending on thetests you may need.

If your insurance requires referral to see a specialist please ensure it is obtained prior to your visit date. If you need help with that or have questions about any other aspect of your visit please feel free to call us at **304-343-4300.**

We look forward to serving you.

Sincerely yours

Asthma and Allergy Center

*Besides the completed forms, please bring your Govt. issued photo ID (of the responsible person if other than the patient), health insurance and prescription cards, bottles of current medications if you are on more than two or three, and any referral documents or test reports your doctor may have given you.

**Many prescription and over the counter medications for cough, colds, allergies, sinus, sleep, mental health, vertigo, motion sickness, nose sprays, eye drops etc. contain antihistamines.

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208 MacCorkle Ave. SE, Charleston, WV 25314
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Patient's Name_____ Age_____ Birthdate_____ ☐Male ☐Female

Race/Ethnicity: ○Caucasian ○African-American ○Asian-American ○Hispanic ○Native -American Other: _____

Address_____ City_____State_____ Zip _____

SS #: _____ Email: _____ Cell #: _____ Home #: _____

Patient's Employer: _____ Work Phone #: _____

Marital Status: ○Single ○Married ○Widowed ○Divorced ○Separated Student ? ○yes ○no

Spouse's Name: _____ Cell phone: _____ Email: _____

Spouse"s Employer: _____Workphone #: _____

Are any family members patients here? ○no ○yes. If yes, who?_____

Name and address of a close relative not living with you: Name_____

Address _____ Home Phone _____

IF PATIENT IS A MINOR:

Mother's Name: _____ Cell #: _____ Employer: _____

Father's Name: _____ Cell #: _____ Employer: _____

Legal Guardianship: ○Parents ○Mother Only ○Father Only ○Other: _____

REFERRING PHYSICIAN / PCP INFORMATION:

Doctor who referred for consultation:_____ Tel No._____ Location:_____

Patient's Primary Care Physician:_____ Tel No._____ Location:_____

PRESCRIPTION CARD INFORMATION:

	Company Name	**Card I.D. No.**		
1st	_____	_____	||	**Your Pharmacy Name:** _____
2nd	_____	_____	||	**Location:**_____ **Tel No:**_____

HEALTH INSURANCE: (You MUST bring your insurance cards with you.)

1st Company Name: _____ Policy No. _____ Eff Dates: from_____ to_____

Policyholder's Name: _____D.O.B.: _____ SS#: _____ Rel to Patient: _____

Address :_____ Home #:_____ Work #:_____ Cell #:_____

2nd Company Name:_____ Policy No._____ Eff Dates: from_____ to_____

Policyholder's Name: _____ D.O.B.:_____ SS #: _____ Rel to Patient: _____

Address :_____ Home #:_____ Work #:_____ Cell #:_____

Patient's Name: . . . . . .

Does your insurance require referral or pre-certification to see a specialist? ◯ No ◯ Yes ◯ Don't Know

Is treatment of allergies covered by your Insurance? ◯ No ◯ Yes ◯ Don't Know

How much is your deductible? $ _____ Is it ◯ yearly? ◯ half yearly? Is it ◯ per person? ◯ whole family?

Have you met your deductible for this year? ◯ Yes ◯ No In which month does your deductible start?

How did you learn about us? _____Text

PAYMENT & BILLING POLICIES

For Medicare, Medicaid and insurance programs that list us as preferred provider, you are responsible only for the deductible and copayments, **which must be paid at check out time**. We will submit and follow up the insurance claims.

For all other insurance policies, the deductible, copayment and coinsurance **must be paid at check out time**. We will submit your insurance claim if you wish, but you must follow up with your insurance company. In all cases you are responsible for whole or any part of the bill not covered by insurance.

If you are unable to pay as above at check out time, **please call in advance or see the receptionist before you see the doctor** to make alternate arrangements.

We accept Visa / MC / Discover.

CONSENTS:

With respect to the patient described on this form, and for services performed by any medical provider at or on behalf of Asthma and Allergy Center, I agree and give my consent and permission to Asthma & Allergy Center as follows:

1. To conduct medical tests and give medical treatment as per the provider's best judgment.
2. Use this form as authority to submit bills and receive payments from my Health Insurance Companies.
3. To release any or all information and to send medical reports to my Health Insurance Companies, the referring doctor, the primary doctor and any other doctor treating the patient and as described in the Privacy Notice I have received, read and reviewed.
4. To contact me by telephone, email or text messages and leave messages on answering machine for test results, missed appointments and appointment reminders at telephone numbers and email addresses given to Asthma & Allergy Center.
5. To send me Practice Newsletters and Informational / Promotional material by email or text message.
6. To act as my agent in obtaining payment from my Health Insurance Companies.
7. To use a copy of this authorization in place of the original.

I confirm that I have read and I understand the above statements and that I can cancel any or all above permissions at any time . FURTHER, I confirm that I have read, understood and will abide by the above-mentioned Payment & Billing Policies.

I affirm that all information given on these papers is true to the best of my knowledge; and that I have the legal authority to give the above consents on behalf of myself / or the above-mentioned patient, as applicable.

I confirm that I have received a copy of the Privacy Notice.

Signature of responsible person_____ Date:_____ Witness:_____

Address: _____ SS # _____ Driver's Lic No. _____

FOR OFFICE USE ONLY

☐ Written consultation request / Fax response on file ☐ Awaiting fax response

☐ Privacy Notice given _____(initials & date)

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NEW PATIENT HISTORY

Pt. Name.:_____

This space is for physician's notes

For what illness are you seeking treatment:

D.O.B.: _____

Date: _____

Check Major Symptoms: (If none, please C**heck None**)

NOSE:	☐Itching	☐Running	☐ Sneezing
	☐Stuffiness	☐Nosebleeds	☐ None
EYES:	☐Itching	☐Watering	☐ Swelling
	☐Redness	☐Dark Circles	☐ None
EARS:	☐Itching	☐Blocking	☐Infections
	☐Fluid in Ears	☐Hearing Loss	☐ None
THROAT:	☐Itching	☐Voice Loss	☐ Infections
	☐Hoarseness	☐Post-Nasal Drip	☐ None
CHEST:	☐Coughing	☐ Wheezing	☐Smothering
	☐Shortness of Breath	☐Tightness	☐ Infections
	☐Green/Yellow Sputum	☐ Blood in Sputum	☐ None
HEADACHE:	☐Sinus	☐Facial Pain	☐Tension
	☐Migraine	☐ Other	☐None
SKIN:	☐Hives	☐Eczema	☐Swelling
	☐General Itching	☐ Rash	☐None
ABDOMEN:	☐Nausea	☐Cramps	☐ Vomiting
	☐Indigestion	☐ Diarrhea	☐ None
GENERAL:	☐Fatigue	☐ Feel Sick	☐Infections
	☐Weight Loss	☐ Poor Appetite	☐None

Which of the above are most important to you?

Which of the above are currently bothering you? And for how long?

When did these problems occur for the first time in your life?

Are your symptoms: ☐Constant? ☐In attacks? ☐ Seasonal?
☐Recently getting worse? Explain:

Are you worse in: ☐ Jan. ☐Feb. ☐March ☐April ☐May ☐ June
☐July ☐Aug. ☐Sept. ☐Oct. ☐Nov. ☐Dec.

If attacks: How often do you have them?
How long does each last?
When did you have the last one?

Do you have symptoms all year round? ○n ☐y

Which is your worst season? ☐ Spring ☐Summer ☐Fall ☐Winter
☐All year round

If seasonal or in attacks, are you completely clear of symptoms between spells? ☐n ☐y Explain:

Pt. Name:_____

This space is for physician's notes

How many chest "colds" do you average per year? Explain:

Do you cough, wheeze, feel tight in the chest, or short of breath after exercise? ○n ☐y Explain:

Do you cough, smother or wheeze at night? ○n ☐y

Check any of the following that cause or increase your symptoms:

☐ Housedust	☐ Flowers	☐ Aspirin	☐ Common Cold
☐ Trees	☐ Industrial Fumes	☐ ACE Inhibitor	☐ Air Conditioner
☐ Feathers	☐ Weather Change	☐ Beta Blockers	☐ Excitement
☐ Weeds	☐ Outdoors	☐ Ibuprofen	☐ Insect Stings
☐ Animals	☐ Food Odors		☐ Exertion
☐ Grass	☐ Paints, Varnishes	☐ Beer/Wine	☐ Laughing
☐ Hay/Grain	☐ Soaps/Detergents	☐ Cocktail Shrimp	☐ Dampness/Rain
☐ Mold/Mildew	☐ Cigarette Smoke	☐ Potato Chips	☐ Fatigue
	☐ Cosmetics, perfumes	☐ Salad bar	☐ Cold Air
	☐ Insecticides	☐ Other foods	☐ Menstrual Period
			☐ Temp Change

Are there any foods you cannot eat for reason other than taste? ○n ☐y
If yes, which foods and why?

Have you had an unusual or severe reaction to insect stings? ○n ☐y
Explain:

What treatment have you tried for this illness?

What helped the most?

Do you use nose spray? ○n ☐y Name of spray?

Have you ever taken oral steroids (Prednisone, Medrol, etc.)? ○n ☐y
Explain:

When was the last time you had a chest x-ray? Sinus x-ray? TB test?
What were the results?

Have you had allergy tests before? ○n ☐y When?
By whom?

What were the main positive reactions?

Did you receive "allergy injections"? ○n ☐y
Did they help? ○n ☐y

If applicable, are you pregnant? ○n ☐y BirthControl? n○ y☐

If child, is he/she up-to-date on immunizations? ☐n ○y

Have you ever had pneumonia vaccine? ☐n ☐y Flu vaccine? ○n ☐y

Is patient or any Family Member Allergic to PENICILLIN or CEPHALOSPORIN ?
Explain:

ENVIRONMENTAL HISTORY Pt. Name:_____

This space is for physician's notes

How many beds in patient's bedroom?

Are there feather pillows in the house? ○n ☐y

Plastic covers on mattress and pillows? ○n ☐y

Mattresses are: ☐Innerspring ☐Waterbed ☐Cotton ☐Polyfoam ☐Other

Carpeting in bedroom? Rug Pad?

Drapes? Upholstered Furniture?

Stuffed Animals? Type of Heating System?

Air Conditioning? Electronic Filter?

Do you have pets or other animals around the house? ○n ☐y

What kind?

In or out of the house?

Is the area around your house damp or moldy? ○n ☐y
Explain:

Is there any mold or mildew growth inside your house? ○n ☐y
Explain:

Is there anything else around the house you suspect of causing your symptoms? ○n ☐y Explain:

Are there any special dusts or fumes where you work? ○n ☐y
Explain:

Tobacco Use:

☐Never smoked or less than 100 cigarettes in lifetime

☐Current non-smoker: smoked for _____ years average ____ packs/day
quit _____ months/years ago

☐Current smoker: ☐1-3 cig/day ☐½ -1 pack/day ☐1-2 packs/day

☐Non-smoker but exposed to second-hand smoke at home or elsewhere?

Do you use smokeless tobacco? ○n ☐y

PAST ILLNESSES: Has patient ever had any of the following?

☐Asthma	☐Nasal Polyps	☐Adenoidectomy
☐Hives	☐Bronchitis	☐Sinusitis
☐Tubes In Ears	☐Welts	☐Pneumonia
☐Ear Infections	☐Sinus Operation	☐Eczema
☐Hay Fever	☐Tonsillectomy	☐Nasal Surgery
☐Dermatitis	☐High Blood Pressure	☐Diabetes
☐Heart Disease	☐Tuberculosis	☐Peptic Ulcer
☐Liver Disease	☐Hiatal Hernia	☐Kidney Disease
☐Gastric Reflux	☐Leg Vein Thrombosis	☐Arthritis

Any other Illnesses**:** Explain:

FAMILY MEDICAL HISTORY (check if yes)

Have any BLOOD RELATIVES OF THE PATIENT had any of the following?

☐Bronchial Asthma	☐Hives	☐Migraine	☐Food Allergy
☐Emphysema	☐Hay Fever	☐Sinus	☐Eczema
☐Nasal Polpys	☐Bronchitis	☐Other Allergies	

Pt. Name:_____

This space is for physician's notes

Please list all H**ospitalizations** with approximate dates and diagnosis.

	Reason	Date
1.		
2.		
3.		
4.		

List all S**urgeries** with approximate dates and diagnosis.

	Surgery	Date	Diagnosis
1			
2.			
3.			
4.			

List all C**urrent Medical Problems** other than those you are coming to see us for, with approximate date and treatment you are taking.

	Problem	Date of Diagnosis	Treatment
1.			
2.			
3.			
4.			

List all C**urrent Medications** you are taking, including supplements and herbals with approximate dates when started. If more than two, pl bring all current bottles with you.

For Allergic Rhinitis / Asthma:	Date Started
1.	
2.	
3.	
4.	

For other illness:	Date Started
1.	
2.	
3.	
4.	

Are there any **medications you are allergic to or cannot tolerate** for other reasons? ○n ☐y
List all and explain:

1.
2.
3.
4.

_____ **MD**

Physician's Signature & Name