

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 an Antihistamine **, 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 the tests 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.

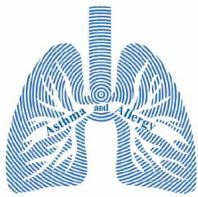
Sincerely yours

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.

This page intentionally left blank



ASTHMA & ALLERGY CENTER

208 MacCorkle Ave. SE, Charleston, WV 25314

Charleston.Beckley.Parkersburg. Ripley.Logan.Montgomery

Asthmaweb.com

304.343.4300

Patient's Name _____ Age _____ Birthdate _____ Male Female

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

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ S.S. # _____

Employer _____ Work Phone _____ Email: _____

Marital Status: Single Married Widowed Divorced Separated Student ? Yes No

Spouse's Name _____ Spouse's Employer: _____

Spouse's Work Phone _____ Spouse's Work Address: _____

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 _____ Employer _____ Work Phone _____ Cell _____

Father's Name _____ Employer _____ Work Phone _____ Cell _____

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.		Your Pharmacy Name:
1 st _____	_____		_____
2 nd _____	_____		Location: _____ Tel No: _____

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

1st Company Name: _____ Policy No. _____ Eff Dates: from _____ to _____

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

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

2nd Company Name: _____ Policy No. _____ Eff Dates: from _____ to _____

Policyholder 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. _____

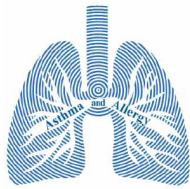
FOR OFFICE USE ONLY

Written consultation request / Fax response on file

Awaiting fax response

Privacy Notice given

_____ (initials & date)



ASTHMA & ALLERGY CENTER

208 MacCorkle Ave. SE, Charleston, WV 25314

Charleston.Beckley.Parkersburg. Ripley.Logan.Montgomery

Asthmaweb.com

304.343.4300

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 **Check None**)

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

- | | | | |
|--------------------------------------|--|--|---|
| <input type="checkbox"/> Housedust | <input type="checkbox"/> Flowers | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Common Cold |
| <input type="checkbox"/> Trees | <input type="checkbox"/> Industrial Fumes | <input type="checkbox"/> ACE Inhibitor | <input type="checkbox"/> Air Conditioner |
| <input type="checkbox"/> Feathers | <input type="checkbox"/> Weather Change | <input type="checkbox"/> Beta Blockers | <input type="checkbox"/> Excitement |
| <input type="checkbox"/> Weeds | <input type="checkbox"/> Outdoors | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Food Odors | | <input type="checkbox"/> Exertion |
| <input type="checkbox"/> Grass | <input type="checkbox"/> Paints, Varnishes | <input type="checkbox"/> Beer/Wine | <input type="checkbox"/> Laughing |
| <input type="checkbox"/> Hay/Grain | <input type="checkbox"/> Soaps/Detergents | <input type="checkbox"/> Cocktail Shrimp | <input type="checkbox"/> Dampness/Rain |
| <input type="checkbox"/> Mold/Mildew | <input type="checkbox"/> Cigarette Smoke | <input type="checkbox"/> Potato Chips | <input type="checkbox"/> Fatigue |
| | <input type="checkbox"/> Cosmetics, perfumes | <input type="checkbox"/> Salad bar | <input type="checkbox"/> Cold Air |
| | <input type="checkbox"/> Insecticides | <input type="checkbox"/> Other foods | <input type="checkbox"/> Menstrual Period |
| | | | <input type="checkbox"/> 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 1/2 -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 Polyps Bronchitis Other Allergies

Pt. Name: _____

This space is for physician's notes

Please list all **Hospitalizations** with approximate dates and diagnosis.

Reason	Date
1.	
2.	
3.	
4.	

List all **Surgeries** with approximate dates and diagnosis.

Surgery	Date	Diagnosis
1.		
2.		
3.		
4.		

List all **Current 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 **Current 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.