

Allergy Profile & Symptoms of Common Allergies Intake Form

Patient Name: _____

Date: _____

Please place a **check** beside the problems you are experiencing:

- | | | | |
|--|---------------------------------------|--|--|
| ☐ Sneezing | ☐ Watery Eyes | ☐ Throat Drainage | ☐ Cough |
| ☐ Runny Nose | ☐ Swollen Lids | ☐ Blocked Ears | ☐ Throat Tickle |
| ☐ Blocked Nose | ☐ Itchy Eyes | ☐ Itchy Ears | ☐ Wheezing |
| ☐ Loss of Smell | ☐ Sore Throat | ☐ Ear Infection | ☐ Tightness in Chest |
| ☐ Headache | ☐ Itchy Mouth | | ☐ Shortness of Breath |

Potentially Caused By: _____

- | | | | |
|---|---|-----------------------------------|---------------------------------------|
| ☐ Itchy Skin | ☐ Lip Swelling | ☐ Nausea | ☐ Irritability |
| ☐ Rash | ☐ Itchy Hands / Feet | ☐ Diarrhea | |
| ☐ Hives and/or Welts | ☐ Stomach Pains | ☐ Fatigue | |

Potentially Caused By: _____

1. How long have you had the above symptoms?

- | | | | | |
|---|----------------------------------|-----------------------------------|------------------------------------|---------------------------------|
| 2. Which seasons are the worst for your symptoms? | ☐ Spring | ☐ Summer | ☐ Fall | ☐ Winter |
| 3. When is the best time of the year? | ☐ Spring | ☐ Summer | ☐ Fall | ☐ Winter |
| 4. What triggers your symptoms? | ☐ Weather | ☐ Exertion | ☐ Infection | |

Please list current medications:

- | | | | |
|---|--|--|--|
| Previous treatments: | ☐ Allergy Testing | ☐ Allergy Testing | ☐ Other Medications |
| Are you allergic to any of the following? | ☐ Animals | ☐ Foods | ☐ Insects |
| | ☐ Dust | ☐ Medicines | ☐ Smoke |

What medications are you allergic to?

- | | | | | | |
|--|---------------------------------|---------------------------------|-----------------------------------|----------------------------------|----------------------------------|
| Does anyone in your family have allergies? | ☐ Yes | ☐ No | ☐ Unsure | | |
| If yes to the above, please indicate: | ☐ Mother | ☐ Father | ☐ Children | ☐ Brother | ☐ Sister |
| Is anyone in your family a patient here? | ☐ Yes | ☐ No | | | |
| Was your home built before 2000? | ☐ Yes | ☐ No | | | |
| Which does your home have? | ☐ Carpet | ☐ A/C | ☐ Plants | ☐ Pets | ☐ Smokers |



Date: _____ Patient Number: _____

Patient Information
Patient Name:

Street Address:

Social Security Number:

Date of Birth:

City & State & ZIP:

Driver's License Number:

Sex:

Home Phone:

Marital Status:

Cell Phone:

Spouse Name:
Emergency Contact:
Primary Physician:

Date of Birth:

Relationship to Patient:

Address

Social Security Number:

Phone:

Phone

Phone:

Cell Phone:

Employer Information
Patient's Employer:

Address:

Phone Number:

Occupation:

City & State & ZIP:

Spouse's Employer:

Address:

Phone Number:

Occupation:

City & State & ZIP:

If Patient is a Minor or Student
Mother's Name:

Address:

Cell Phone:

Date of Birth:

City & State & ZIP:

Business Phone:

Mother's Employer:

Mother's Social Security #:

Driver's License:

Father's Name:

Address:

Cell Phone:

Date of Birth:

City & State & ZIP:

Business Phone:

Father's Employer:

Father's Social Security #:

Driver's License:

Insurance Information
Company:

Insured Person:

Phone Number:

Other Insurance: (If Applicable):

Insured Person:

Phone Number:

Responsible Party (If other than Patient)
Name:

Street Address:

Employer:

Date of Birth:

City & State & ZIP:

Social Security Number:

Relationship to Patient:

Phone:

Driver's License Number:



Assignment of Benefits Form

Financial Responsibility:

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Financial Responsibility:

I hereby assign all medical and surgical benefits, including major medical benefits to which I am entitled. I authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to Allergy & Asthma Care of Waco for medical services rendered to myself and/or my dependents, regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

I have requested medical services from Allergy & Asthma Care of Waco on behalf of myself and/or my dependents, and by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient / Responsible Party Signature:

Date

Witness

Date

Welcome!

We are very pleased that you have chosen the team at Allergy & Asthma Care of Waco to provide gentle solutions for your allergy and asthma needs. We specialize in the complete diagnosis, relief, and prevention of allergies and asthma for both adults and children. Our team is dedicated to creating a pleasant and professional environment for each of our patients.

Important Items to Complete Prior to Your Visit:

1. Notify our office of your insurance coverage.
2. Ensure your Primary Care doctor has obtained a referral.
3. Stop taking all over-the-counter antihistamines at least 24 hours before your appointment.
4. If you are taking an antihistamine, please follow the table below. If you are uncertain about the antihistamine you are taking, please call our office in advance.

DO NOT stop taking any asthma medications.

Antihistamine	Stop taking # days prior to visit
Claritin	10 days
Zyrtec	3-5 days
Allegra	3-5 days

See full list of interfering medications at allergywaco.com/new-patients

Our policy is to collect payment at the time of service, including all co-pays, deductibles, and coinsurances. Attached you will find your benefits as quoted by your insurance company. If you are uncertain about your cost, please contact our office and/or your insurance company.

Failure to provide all of the required information listed above may result in the rescheduling of your appointment. Please complete the enclosed forms and bring them with you to your appointment.

We value your time, so please be prepared to spend 2-2½ hours in our office. We have reserved this time especially for you. If you need to reschedule or cancel your appointment, please call us at least 24 hours in advance at (254) 753-3646. **Failure to do so will result in a \$50.00 no-show fee.**

Please call our office at (254) 753-3646 if you have any questions about your visit.

Please remember to bring your completed forms, insurance and referral with you.

We look forward to your visit!

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone: _____

☐ O.K. to leave a message with detailed information

☐ Leave message with callback number only

☐ Written Communication

☐ O.K. to mail to my home address

☐ O.K. to mail to my work/office

☐ O.K. to fax to this number

☐ Home Telephone: _____

☐ O.K. to leave a message with detailed information

☐ Leave message with callback number only

☐ Other (spouse, child, etc..) _____

Patient Signature

Date

Print Name

Birthdate