New Patient Registration(Please Print Clearly)

ALLERGY ASTHMA & IMMUNOLOGY SPECIALISTS

Patient Information

Last Name_____ **First Name**_____ **Middle Initial** _____ **Preferred**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home # _____ **Work #** _____ **Cell #** _____

Date of Birth _____ **Social Security #**_____

Email Address_____@_____ **Preferred Method to Contact You:** _____

Gender Assigned @ Birth ☐ Male ☐ Female ☐ Other **Gender Identity** ☐ Male ☐ Female ☐ Other

Race ☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ Native Hawaiian/Pacific Islander ☐ Decline

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline **Language** ☐ English ☐ Spanish ☐ Other: _____

Mark All That Apply ☐ Student @ School Name _____ ☐ Retired ☐ Disabled

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employer_____ **Work #** _____

Primary Care Doctor _____ **Who referred you?**_____

Preferred Pharmacy and Address _____

Responsible Party Information *(Please leave this section blank if you are responsible for yourself.)*

Last Name_____ **First Name**_____ **Middle Initial** _____ **Preferred**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home # _____ **Work #** _____ **Cell #** _____

Date of Birth _____ **Social Security #**_____

Email Address_____@_____ **Relationship to Patient** _____

Employer_____ Occupation_____

Emergency Contact

Name _____ **Relationship to Patient** _____

Phone # 1 _____ **Phone # 2** _____

Insurance Information

Is your visit with us related to a work injury or illness? ☐ Yes ☐ No

If Medicare, please check one ☐ Still working or Spouse has Employer Group Health Plan ☐ Disabled Beneficiary under 65 Years of Age

Primary Insurance Company (We will need a copy of the front and back of your insurance card.)

Subscriber Name _____ **Relationship to Patient** _____

Date of Birth _____ **Social Security #**_____

Policy/Member#_____ **Group #** _____

Employer/Place of Work _____

Secondary Insurance Company (We will need a copy of the front and back of your insurance card.)

Primary Insurance Company (We will need a copy of the front and back of your insurance card.)

Subscriber Name _____ **Relationship to Patient** _____

Date of Birth _____ **Social Security #**_____

Policy/Member#_____ **Group #** _____

Employer/Place of Work _____

Patient Consent Form

Today's Date_____

Patient Name: _____

Date of Birth: _____

_____**(Initials)** I have read and understand the **OFFICE POLICIES AND PATIENT RESPONSIBILITIES** and agree to all terms and conditions set forth herein.

_____**(Initials)** I have received the ***Notice of Privacy Practice*** from Allergy Asthma & Immunology Specialists. I understand that I may request a copy of the Notice by asking the receptionist. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its *Notice of Privacy Practices* and to make changes regarding all protected health information under the control of this practice.

_____**(Initials) Evaluation and Treatment**. I consent to diagnostic procedures and medical care as deemed necessary in the judgment of my Physician. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me. However, I understand that my Physician will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

_____**(Initials) Pharmacy Benefit Management (PBM).** Electronic Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Medication History Transactions provide the physician with information about medications that the patient is already taking prescribed by any provider, to minimize the number of adverse drug events. By signing this consent, you agree that Allergy Asthma & Immunology Specialists can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for optimal treatment purposes.

_____**(Initials) Advanced Beneficiary Notice of Non-Covered Services (ABN/NNS).** As your physician and healthcare team, we/I want to provide you with the best possible care. There may be certain routine services/procedures performed during your visit(s), such as but not limited to; breathing test, patch testing, skin testing, food challenges, drug challenges, and/ or other test that we/I feel necessary for the maintenance of your good health that may not be covered by your insurance contract. These tests will only be ordered if deemed necessary to your treatment and care. Anything non-covered by your insurance contract you will be responsible for the total cost. Copayment, co-insurance, and deductibles may apply.

_____**(Initials) Government Compliance**. In compliance with the recently enacted Patient Protection and Affordable Care Act and the Stark Law, Allergy Asthma & Immunology Specialists must inform you that there are other options pertaining to infusion and pharmacy services. Specifically, it should be noted that you have presented to Allergy Asthma & Immunology Specialists voluntarily for your medical needs and that as part of the evaluation of your condition and any required treatment, the clinician may determine that infusion and/or pharmacy services may be needed. Infusion Care of East Alabama and Medicus Specialty Pharmacy offers many of these services as a convenience to our patients. If any patient would like to have their infusion and pharmacy services provided at another location, we can provide you with a list of nearby locations which are available within a 25-mile radius. If I have no preference in providers, Infusion Care of East Alabama and/or Medicus Specialty Pharmacy will be utilized. I am aware Allergy Asthma & Immunology Specialists have an interest in those businesses. I authorize Allergy Asthma & Immunology Specialists to release the necessary information concerning my case history, treatment, and examination for my visit to the above-named businesses.

_____**(Initials) Billing and Collections Policy.** We strive to provide exceptional care to all our patients, but we also must ensure financial sustainability. Patients are responsible for timely payment of co-payments, deductibles, and outstanding balances. If an account becomes past due and our efforts to collect payment are unsuccessful, then your account will be turned over to a Collection's Agency. Please note that accounts sent to the Collection Agency will incur **an additional 20% fee** on the outstanding balance to cover the collection costs. We encourage patients facing financial difficulties to contact our billing department for assistance with payment options as we are committed to finding reasonable payment solutions.

_____**(Initials) Medical Data Exchange.** Medical data may be exchanged through networks facilitated by the Interoperability Hub, such as Carequality and Commo l. This enables seamless sharing of your health information among authorized healthcare providers for improved coordination and continuity of care.

☐ Opt-In: I **do** consent to the exchange of my medical data through networks facilitated by the Interoperability Hub for sending or receiving documents

☐ Opt-Out: I **do not** consent to the exchange of my medical data through networks facilitated by the Interoperability Hub for sending or receiving documents.

By signing below, I hereby agree and understand the Office Policies and Patient Responsibilities, Notice of Privacy Practice, Evaluation and Treatment, PBM, ABN/NNS, Government Compliance, Billing Collections Policy, and Medical Data Exchange:

Signed:_____**Print:** _____**Date:** _____/_____/_____

Patient

Signed:_____**Print:** _____**Date:** _____/_____/_____

Guardian

Guardian's Relationship to Patient:_____

Consent to Disclose
Medical Information Authorization

Today's Date_____

Patient Name: _____

Address: _____

_____

Date of Birth: _____

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy rules.
3. I understand that I may revoke this authorization at any time by notifying our office in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the renovation, and Allergy Asthma & Immunology Specialists will not be liable for any PHI released prior to me revoking this authorization.
4. I understand that by leaving spaces blank I am indicating that I do not want any medical information released to anyone else.
5. I understand that this authorization will expire: _____. (***if no date this authorization will expire after 1 year***)

Disclose Information to the following:

(List any doctors or individuals you would like to have access to your information.)

Name:_____ Name: _____

Relationship to patient:_____ Relationship to patient:_____

Phone number:_____ Phone number: _____

Guardian Information for Minors: ***(if guardians are not listed below, they will not have authorization to your medical records)***

Guardian Name:_____ Guardian Name: _____

Relationship to patient:_____ Relationship to patient:_____

Phone number:_____ Phone number: _____

By signing below, I hereby authorize Allergy Asthma & Immunology Specialists to release any or all my medical records to the following individuals, physicians, or companies:

Signed:_____ **Print:** _____ **Date:** _____/_____/_____
Patient

Signed:_____ **Print:** _____ **Date:** _____/_____/_____
Guardian

Guardian's Relationship to Patient:_____

Allergy Asthma & Immunology Specialists
New Patient History Form

Patient Name (Dr. Mr. Mrs. Ms.)_____**Age**:_____**DOB:**_____**Today's Date:** _____

If patient is a minor, Parent/Guardian name and relationship_____

If patient has any Special Needs (Deaf, Mute, Mentally Challenged) please list: _____

Who is your Primary Care Physician?_____

Doctor who referred you to see us? _____

If not, Doctor referred, how did you hear about us?_____

Name of Pharmacy:_____**Address of Pharmacy:** _____

What have you been referred for? OR What is your main Allergy, Asthma, Immune System concern?

_____

Review of Systems:

Please check if you have recently experienced any of the following:

General:
- ☐ fever
- ☐ chills

Eyes:
- ☐ dry eyes
- ☐ watery eyes
- ☐ itchy eyes

Ears, Nose, Throat:
- ☐ runny Nose
- ☐ postnasal drainage
- ☐ sore throat
- ☐ nosebleeds
- ☐ sneezing
- ☐ hoarseness of voice

Respiratory:
- ☐ shortness of breath
- ☐ wheezing
- ☐ cough
- ☐ vomit after coughing

Gastrointestinal:
- ☐ heartburn
- ☐ nausea
- ☐ vomiting
- ☐ diarrhea
- ☐ trouble swallowing

Genitourinary:
- ☐ Trouble starting urine

Integument:
- ☐ skin itches
- ☐ dry skin
- ☐ rash
- ☐ hives/welts

Psychiatric:
- ☐ fearful, anxious
- ☐ excessive worry

NURSE NOTES:

Personal and Family Medical History

	Patient	Father	Mother	Sibling	Child
Nose Allergy	☐	☐	☐	☐	☐
Eye Allergy	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Eczema (Atopic Dermatitis)	☐	☐	☐	☐	☐
Food Allergy	☐	☐	☐	☐	☐
Drug Allergy	☐	☐	☐	☐	☐
Insect Allergy	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐
Angioedema	☐	☐	☐	☐	☐
Autoimmune Disorder (Rheumatoid)	☐	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐	☐
Migraine	☐				
Meningitis	☐				
Thyroid	☐				
Diabetes	☐				
Glaucoma	☐				
High Blood Pressure	☐				
Cancer	☐				
Stroke	☐				
Heart Disease	☐				
Bleeding Disorder	☐				
Heartburn or Reflux	☐				
Hepatitis (Liver)	☐				
Kidney Disease	☐				
Arthritis	☐				
Epilepsy/Seizures	☐				
Anxiety	☐				
Depression	☐				
HIV (OPTIONAL)	☐				

List Any Other Medical Problems:

Hospitalization: ☐ None
*Please include year of hospitalization

_____

Surgical History ☐ None
Please include year of surgical procedure

_____
_____
_____
_____

Current Medications: ☐ None ☐ List Provided
Please include as needed medications

_____
_____
_____
_____

Drug Allergies ☐ None

_____
_____
_____
_____

Personal / Social History:

Are you currently Pregnant? **Yes** ☐ **No** ☐
Are you currently Breast feeding? **Yes** ☐ **No** ☐
Do you smoke? **Yes** ☐ **No** ☐
Did you used to smoke? ☐ **Yes** **No** ☐
How many years? _____
How many packs per day? _____
When did you quit? _____
Exposed to cigarette smoke? **Yes** ☐ **No** ☐
Do you drink alcohol? **Yes** ☐ **No** ☐
How many drinks per week? _____
Do you use recreational drugs? **Yes** ☐ **No** ☐

Environment:

Occupation: _____
Do you live in a **house**, **apartment**, **condo**, or **mobile home**?
How old is the home? _____
Carpet? **Yes** **No** Which rooms? _____
Indoor pets: _____
Outdoor pets/animals: _____
Air conditioning: **central** or **window units**?
Pillow: **feather**, **foam**, or **polyester fiber**?
Bed: **regular**, **feather**, or **waterbed**?
Do you use a **air purifier**, **ceiling fans**, or **fireplace?**