PATIENT INFORMATION SHEET

DATE: ____________________

LAST NAME: ______________________ FIRST NAME: ______________________

STREET ADDRESS: ______________________

CITY: ______________________ STATE: __________ ZIP: __________

PRIMARY PHONE: __________ CELL PHONE: __________ TEXT: Y OR N

SEX: M / F / T DATE OF BIRTH: / / EMAIL: __________

SSN #: __________ RACE: __________ ETHNICITY: __________

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED/ER DOMESTIC PARTNER

PRIMARY CARE PHYSICIAN: __________ REFERRING PHYSICIAN: __________

HOW DID YOU HEAR ABOUT US? __________ EMERGENCY CONTACT: __________

EMERGENCY CONTACT PHONE NUMBER: __________ RELATIONSHIP TO PATIENT: __________

MEDICAL HISTORY

WHAT IS YOUR MAIN REASON FOR SEEING US TODAY? __________

WHEN IS THE LAST TIME YOU TOOK AN ANTIHISTAMINE? __________

WHAT IS THE NAME AND LOCATION OF YOUR PHARMACY? __________

HAVE YOU RECEIVED BOTH COVID VACCINES? __________ WHICH VACCINE? __________

CURRENT MEDICATIONS

NAME OF DRUG	DOSAGE	HOW OFTEN TAKEN?

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES / NO (IF YES, PLEASE LIST MEDICATIONS AND REACTIONS.)

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FAMILY MEDICAL HISTORY

HAS A FAMILY MEMBER (LIVING OR DECEASED) BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

	Y / N	FAMILY MEMBER
ANAPHYLAXIS		
ANGIOEDEMA		
ASTHMA		
CANCER		
EZCEMA		
DIABETES		

	Y / N	FAMILY MEMBER
FOOD ALLERGIES		
HIGH BLOOD PRESSURE		
IMMUNODEFICIENCY		
LUPUS		
OTHER ALLERGIES		
THYROID DISEASE		

SURGICAL HISTORY

LIST ANY SURGERIES BELOW:

SURGERY: ______________________________ **APPROXIMATE DATE:** ____________

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HAVE YOU EVER HAD ANY OF THE FOLLOWING

	Y / N		Y / N		Y / N
ANXIETY DISORDER		HEADACHES		OTHER SKIN CONDITION	
ASTHMA		HEART ATTACK		PNEUMONIA	
BRONCHITIS		HIGH CHOLESTEROL		RHINITIS	
COPD		HIVES		SLEEP DISORDER	
CANCER		HYPERTENSION		STROKE	
DEPRESSION		KIDNEY DISEASE		THYROID PROBLMES	
DIABETES		LIVER DISEASE		TONSIL INFECTIONS	
ECZEMA		MIGRAINES		TUBERCULOSIS	
FOOD ALLERGY		NASAL/SINUS PROBLEMS		OTHER: PLEASE LIST	
GERD/REFLUX		NASAL POLYPS			
GLAUCOMA		OSTEOPOROSIS			

SOCIAL HISTORY

TYPE OF RESIDENCE: **SINGLE LEVEL HOME** **MULTI LEVEL HOME** **APARTMENT** **TRAILER** **CONDO** **OTHER**

HOW LONG HAVE YOU LIVED IN YOU CURRENT RESIDENCE?________________

APPROXIMATELY HOW OLD IS YOUR HOME?____________________________

DO YOU HAVE CARPETING IN YOUR HOME? Y / N

DO YOU HAVE PETS? Y / N **IF SO, WHAT KIND?** ____________________________

DO YOU HAVE A HUMIDIFIER? Y / N **IS YOUR HOME AIR CONDITIONED?** Y / N

DO YOU HAVE PASSIVE SMOKE EXPOSURE? Y / N **IS THERE A SMOKER IN YOUR HOME?** Y / N

ARE YOU A SMOKER/TOBACCO USER? Y / N **IF SO, HOW MANY PACKS A DAY DO YOU SMOKE?**____________________

ARE YOU EXPERIENCING ANY OF THE FOLLOWING TODAY?

General/Constitutional: Change in Appetite Chills Fatigue Lightheadedness
Fever Night sweats Weight gain/loss Exercise Intolerance Sedation Lethargy

Eyes: Watering Discharge Bloodshot/Red eyes Dry eyes Irritation/Itching
Vision change

Ear/Nose/Throat: Ringing in the ears Difficulty hearing Ear pain Decreased sense of smell
Frequent nosebleeds Nose problems Sinus problems Difficulty swallowing
Swollen glands Sore throat Bleeding gums Snoring Dry mouth
Oral abnormalities Mouth ulcer Teeth abnormalities Mouth breathing

Cardiovascular: Cyanosis Dyspnea on exertion Swollen legs Irregular heartbeat
Chest pain Arm pain Known heart murmur Light-headed on standing

Respiratory: Chest Pain Sputum production Pain with inspiration Cough
Wheezing Shortness of breath Coughing up blood Sleep apnea

Gastrointestinal: Difficulty swallowing Abdominal pain Nausea Vomiting
Constipation Change in appetite Black or tarry stool Diarrhea
Vomiting blood Dyspepsia/Indigestion GERD

Musculoskeletal: Joint stiffness Leg Cramps Painful joints Muscle aches
Weakness Back pain Swollen joints

Skin: Acne Discoloration Eczema Sun sensitivity Skin cancer
Skin oozing Abnormal mole Jaundice Rash Itching Dry skin
Scaly lesions of skin/scalp

Neurologic: Loss of consciousness Weakness Numbness Seizures
Dizziness Headache Restless legs Tremors

Psychiatric: Stressors Substance abuse Depressed mood Difficulty sleeping
Alcohol abuse Anxiety Hallucination Suicidal thoughts

Endocrine: Difficulty sleeping Vertigo Excessive sweating Excessive thirst
Frequent urination Heath intolerance Hot flashes Irregular menses Fatigue
Increased thirst Hair loss Cold intolerance

Allergy/Immunology: Sneezing Wheezing Allergic reaction Runny nose
Congestion Itching Hives Frequent sneezing Blistering of skin Rash

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, ACKNOWLEDGEMENT OF PRIVACY PRACTICES

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Breathe Easy Allergy, LLC for services furnished by Breathe Easy Allergy, LLC. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If I have other insurance coverage, my signature authorizes releasing the information to the insurer or agency shown. Breathe Easy Allergy, LLC accepts the Medicare allowable determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services.
2. **PARTICIPATING INSURANCE AND RELEASE OF INFORMATION:** I understand that Breathe Easy Allergy, LLC may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or other third party. Breathe Easy Allergy, LLC may also tell my health plan and/or referring physician about a treatment I am going to receive to obtain prior approval or to determine whether my plan will cover the treatment, to facilitate payment, or the like.
3. **NON-PARTICIPATING WITH PATIENT'S INSURANCE:** The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Breathe Easy Allergy, LLC if I belong to a plan that Breathe Easy Allergy, LLC does not participate with.
4. **NON-COVERED SERVICES:** The undersigned accepts full financial responsibility for all items and services which are determined by my insurance plan not to be covered. The undersigned agrees to cooperate with Breathe Easy Allergy, LLC to obtain necessary healthcare service plan authorizations.
5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Breathe Easy Allergy, LLC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Breathe Easy Allergy, LLC for payment.
6. **FINANCE CHARGES:** I agree to pay a finance charge of 1% per month, compounded, for any balance I am responsible for which is over 60 days old. I also agree to pay for any returned check fees incurred by Breathe Easy Allergy, LLC. It is the policy of Breathe Easy Allergy, LLC to charge a fee no less than $25.00 for checks that are returned. I understand that Breathe Easy Allergy, LLC has the right to charge a non- refundable fee of $25 for any missed appointment(s). I also agree that if I am the parent/guardian bringing a child in for treatment that I am responsible for all fees incurred by the child. If an account is sent to a collection agency or attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Breathe Easy Allergy, LLC. If co-payments and/or deductibles are designed by my insurance company or health plan, I agree to pay them to Breathe Easy Allergy, LLC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.
7. **ACKNOWLEDGEMENT OF PRIVACY PRACTICES:** I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Breathe Easy Allergy, LLC. There is also a copy posted in the office. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer.
8. **CONSENT:** I hereby authorize the doctors and staff of Breathe Easy Allergy, LLC to administer or perform medical treatment including procedures or services as the may deem necessary or reasonable, including laboratory services and diagnostic procedures. Additionally, I authorize Breathe Easy Allergy, LLC to obtain my medication history.
9. **CONSENT AND ACKNOWLEDGEMENT:** I hereby acknowledge the use of video surveillance inside and outside of Breathe Easy Allergy, LLC and understand that it is beneficial to staff and patient safety and property security.

PATIENT SIGNATURE

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SIGNATURE OF PATIENT'S REPRESENTATIVE

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RELATIONSHIP TO PATIENT

PATIENT NAME (PRINT) **DATE**

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CANCELLATIONS/NO-SHOWS

If you are unable to keep an appointment, please notify the office as soon as possible. This courtesy allows us to give appointments to another patient. **IF YOU DO NOT CANCEL YOUR APPOINTMENT WITHIN 24 HOURS OF YOUR SCHEDULED APPOINTMENT, A $50.00 FEE WILL BE CHARGED TO YOUR PATIENT ACCOUNT BALANCE.**

A 'no-show" is someone who misses an appointment without canceling within 24 hours of their scheduled appointment time. Failure to present at the time of the schedule appointment will be recorded in the patient's record as a "no-show" and a $50.00 fee will be charged to your patient account balance.

WHEN THREE (3) "NO SHOW" APPOINTMENTS HAVE BEEN DOCUMENTED YOU WILL RECEIVE A LETTER FROM THE PHYSICIAN DISCHARGING YOU FROM THE PRACTICE.

We will offer 30 days of emergent care only and transfer your records when you find a new physician.

PATIENT NAME

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PATIENT SIGNATURE

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SIGNATURE OF PATIENT'S REPRESENTATIVE

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RELATIONSHIP TO PATIENT

____ **DATE:** ______________________