AIR Care

Adult New Patient Information

Name Patient Goes By ______________________

Patient Full Name ______________________ Gender M / F __________ Date of Birth __________

Mailing Address ______________________

City ______________________ State __________ Zip Code __________

Home Phone __________ Alternate Phone __________ Phone Type __________

Employer ______________________ Occupation __________

Referring Doctor __________ Referring Doctor Phone __________

Primary Care Physician (PCP) __________ PCP Phone Number __________

Patient's E-mail Address ______________________ E-Mail Type work / home

Have we seen any of your family members before? YES / NO If yes, patient's name __________

Marital Status MARRIED / SEPARATED / DIVORCED / WIDOWED / SINGLE

INSURANCE INFORMATION

Insured Under: ☐ Self ☐ Spouse ☐ Other

Employer ______________________ Occupation __________

Insurance Company ______________________ Eligibility / Benefits Phone __________

Policy ID Number / Subscriber ID __________ Group Number __________

Please provide the following information on the insured person. If you are self - insured, please leave this section blank.

First Name __________ Middle Initial ______ Last Name __________

Gender M / F __________ DOB __________ Relationship to Patient __________

Street Address ______________________ Home Phone __________

City __________ State __________ Zip Code __________ Work Phone __________

EMERGENCY CONTACT INFORMATION

Emergency Contact information will be utilized when we are unable to reach you at any of the above given phone numbers / address.

Primary Contact (not living with patient) __________ Phone Number __________

Address ______________________ Relationship to Patient __________

PHARMACY INFORMATION

Please provide the information for your local pharmacy. The information listed here will be used to call in prescriptions when refills or new prescriptions are needed.

Pharmacy ______________________ Phone Number __________

Address ______________________

How Did You Hear About Us ?

____

____

AIR Care
Allergy, Immunology & Respiratory Care, PA

ADULT MEDICAL HISTORY

Patient Goes By: ____________________

Patient Name: ____________________ ID #: __________ Sex: M / F Age: ________ Date: __________

Immunizations up to date: *Diptheria/ Tetanus Vaccine* ☐ Yes ☐ No *Prior Flu Vaccine* ☐ Yes ☐ No *Pneumovax/Prevnar* ☐ Yes ☐ No

Current Allergy or Asthma Medications ____________________

Prior Allergy or Asthma Medications (did they help or were there problems) ____________________

Current Other Medications ____________________

Current vitamins, herbals or non-prescription meds ____________________

Drug Allergies or Reactions

Medication ____________ Approximate Date ____________ Describe Reaction ____________

Hospitalizations

Age ________ Reason ____________________ Hospital ____________

Surgeries

Age ________ Type of Surgery ____________________ Results ____________

Family History

	Mother	Father	Brothers	Sisters	Other
Tuberculosis or Other Lung Diseases	☐	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐	☐
Chronic Bronchitis or Emphysema	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Nasal or Sinus Allergies	☐	☐	☐	☐	☐
Eczema or Skin Rashes	☐	☐	☐	☐	☐
Food Allergies	☐	☐	☐	☐	☐
Drug or Medication Allergies	☐	☐	☐	☐	☐
Stinging Insect Reactions	☐	☐	☐	☐	☐
Allergy or Sensitivity to Aspirin	☐	☐	☐	☐	☐
Recurrent Infections or Pneumonia	☐	☐	☐	☐	☐
Immune System Disorders	☐	☐	☐	☐	☐
HIV / AIDS	☐	☐	☐	☐	☐

Social History

Exposure to cigarette/cigar smoke ☐ yes ☐ no ____________

Pets at home ☐ yes ☐ no ☐ cat ☐ dog ☐ other ____________

Pets away from home ☐ yes ☐ no ☐ cat ☐ dog ☐ other ____________

Living Environment ☐ Apartment ☐ Home Age of Apt. / Home: ________ Foundation: Pier & Beam Slab

Wall to Wall Carpeting
In house ☐ yes ☐ no
In bedroom ☐ yes ☐ no

Pillow Type: synthetic down/feather Allergy encased/ proofed yes no

Bed Cover Type: synthetic cotton down/feather Allergy encased/ proofed yes no

Ceiling Fans in Bedroom ☐ yes ☐ no

Pets sleep on your Bed ☐ yes ☐ no

Humidifiers in House ☐ yes ☐ no

Water Leaks/Contamination ☐ yes ☐ no

Are you aware of any work related exposures: ____________________

ADULT MEDICAL HISTORY

Patient Goes By: ______________________

Patient Name: ______________________ ID #: __________ Sex: M / F Age: ________ Date: __________

Review of Systems:

Please check all conditions you have currently or have had in past.

HEART ☐ none

- ☐ chest pain
- ☐ irregular heart beat
- ☐ skipped beats
- ☐ palpitations
- ☐ other ______________________
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ stroke
- ☐ heart failure
- ☐ heart attack

DIGESTIVE ☐ none

- ☐ chronic nausea or vomiting
- ☐ indigestion or heartburn
- ☐ gastric reflux
- ☐ stomach ulcers
- ☐ other ______________________
- ☐ bloating or cramping
- ☐ diarrhea
- ☐ constipation
- ☐ colitis or diverticulitis
- ☐ Crohn's disease

URINARY ☐ none

- ☐ burning urination
- ☐ odor on urination
- ☐ other ______________________
- ☐ dribbling or incontinence
- ☐ difficult urination
- ☐ blood in urine

REPRODUCTIVE ☐ none

FEMALE

- ☐ pregnant or anticipating pregnancy
- ☐ miscarriages or infertility problems
- ☐ cysts or tumors
- ☐ other ______________________

MALE

- ☐ infertility problems
- ☐ cysts or tumors
- ☐ undescended testis
- ☐ other ______________________

SKELETAL ☐ none

- ☐ fractures
- ☐ retained baby teeth / delayed permanent teeth
- ☐ scoliosis or spine abnormalities
- ☐ other ______________________
- ☐ arthritis or joint pain
- ☐ joint swelling
- ☐ hyper extendable joints
- ☐ osteoporosis

NEUROLOGICAL ☐ none

- ☐ headaches
- ☐ seizures
- ☐ fainting / black outs
- ☐ other ______________________
- ☐ dizziness
- ☐ numbness
- ☐ depression
- ☐ insomnia or trouble sleeping

ENDOCRINE ☐ none

- ☐ thyroid problems
- ☐ growth or pituitary problems
- ☐ diabetes
- ☐ other ______________________

8440 Walnut Hill Lane Suite 350 Dallas, Texas 75231
3600 Communications Parkway, Suite 675 Plano, Texas 75093

(214) 373-1773 Fax (214) 373-1316
(972) 473-7544 Fax (972) 473-7545

AIR Care
Allergy, Immunology & Respiratory Care

PHARMACY INFORMATION

Pharmacy's Name: ______________________________

Address: ______________________________

City: ____________ State: ______ Zip Code: ____________

Pharmacy's Phone Number: ______________________________

Pharmacy's Fax Number: ______________________________

MEDICATIONS	INSTRUCTIONS	DOSE/STRENGTH	START DATE

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

CONSENT FOR MEDICAL SERVICES

I consent to treatment, diagnostic and/or therapeutic services as ordered by a physician of Air Care Allergy Immunology & Respiratory Care PA and his/her designee(s).

FINANCIAL AGREEMENT

The undersigned individually obligates him/herself and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. Payment of any unpaid balance is due within 30 days of final billing. If payment is not received within 30 days of the date of final billing, finance charges may begin to accrue at the maximum rate allowable by law. In addition such balance may be turned over for collection activity, at which time the undersigned shall be liable for attorney's fees and/or collection agency's fees and expenses. The undersigned understands that he/she has the right to examine Air Care Allergy Immunology & Respiratory Care PA credit bureau files for financial information regarding collection or unpaid debt.

ASSIGNMENT OF BENEFITS

In the event that I am entitled to physician benefits of any and all types, I assign such benefits to Air Care Allergy Immunology & Respiratory Care PA for services rendered to me. I authorize payment directly to Air Care Allergy Immunology & Respiratory Care PA of all such insurance benefits payable to me. Such insurance includes, but is not limited to, private commercial insurance, auto/liability insurance, or any governmental program such as Medicare, Medicaid or Worker's Compensation and authorize Air Care Allergy Immunology & Respiratory Care PA to release medical information to such insurance providers as necessary to satisfy conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is accurate and current.

RELEASE OF INFORMATION

I also authorize Air Care Allergy Immunology & Respiratory Care PA to release all or part of my medical record information when required or permitted by law or government regulation, including any physician(s) or healthcare provider responsible for continuing my care.

INSURANCE PRECERTIFICATION

I understand that, before service is rendered, I personally am responsible for any required notification to my insurance company to obtain authorization for treatment. If this is not done, insurance benefits may be reduced and I am responsible for all charges not covered by my insurance.

LIFETIME MEDICARE B & MEDIGAP SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in the Air Care Allergy Immunology & Respiratory Care PA, including physician services. I authorize any holder of medical or other information about me to release to the Centers of Medicare & Medicaid Services or its agents any information needed to determine these benefits or benefits for related services.

____
Name of Beneficiary

____
HIC Number

LIFETIME MEDIGAP SIGNATURE AUTHORIZATION

I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits for related services.

____
Name of Medigap Insurer

____
Name of Beneficiary

____
Medigap Policy Number

CONSENT FOR MEDICAL SERVICES & TREATMENT

I have been provided with a copy of the HIPAA Notice of Privacy Practices that describes how Air Care Allergy Immunology & Respiratory Care PA may use and disclose my health information, and also describe my rights regarding my health information.

EVALUATION OR SERVICES AND FOLLOW UP

I give permission for Air Care Allergy Immunology & Respiratory Care PA and/or it's agent(s) to contact me for the purpose of evaluation of the services rendered to me.

☐ YES ☐ NO

____
Signature of Patient or Legally Authorized Representative

____/_____/____
Print Name of Patient or Legally Authorized Date

____
Signature of Guarantor of Payment
(state relationship if other than patient)

____/_____/____
Print Name of Guarantor of Payment Date

Notice of Privacy Practices (NPP)

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information: 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities to maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

____

Name of Patient

Patient's Signature : ________________________________ ***Date:*** _________________

____

Name of Patient Representative

Representative's Signature: ______________________ ***Date:*** _______________

FOR INTERNAL USE ONLY

________________________________ ________________________________

Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

☐ Patient was unable to sign

☐ Patient refused to sign

☐ Other: ____

Late Cancellation and No-Show Policy

This policy has been established to provide the highest level of service to all our patients. It has been proven that consistent attendance provides for the greatest opportunity for better health and success. By providing us notice of a cancellation, we can accommodate other patients with your appointment slot.

- Patients must call at least 24 hours prior to their scheduled time, when they knowingly are unable to make their appointment. Cancellations within or less than 24-hours of the appointment will be considered a late cancellation.
- We do understand emergencies arise and it may not be possible to give a 24 hour notice. Exceptions to the Late Cancellation/No-Show policy will be made based on your cancellation history and your provider.
- As a courtesy, patients will receive telephone reminders of the appointment date and time two business days prior to scheduled appointment (unless the patient chooses not to be called). Patients will be provided copies of their scheduled appointments. It is your responsibility to provide us the correct contact information.
- Cancellations can be made anytime by calling our office.

Cancellation Notice Requirements:

Office Visit: 24 hours advance notice.
Failure to provide the required notice will result in a **cancellation fee of $50.00.**

Procedure Visits: 48 hours advance notice
Failure to provide the required notice will result in a **cancellation fee of $100.00.**
This will be charged on all cancelled or no shows for patch testing, intradermal testing, allergy testing, food challenges, antibiotic challenges, and RUSH immunotherapy.
OIC patients will be handled on an individual basis.

Thank you for trusting us with your medical care and your cooperation in helping us to provide quality care and service to all our patients.

The undersigned acknowledges receipt of Allergy, Immunology, and Respiratory Care's Late Cancellation and No-Show Policy:

______________________________ __________________
Patient Signature Date

______________________________ __________________
Printed Name Date

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