ALLERGY AND ASTHMA CLINIC, PC **Christina M. Abraham, MD**

Patient's name _____ Date_____ MR# _____

Date of birth _____ Age _____ Social Security #: _____

Address _____City_____State_____Zip_____

Home phone _____ Cell phone _____ Email: _____

Sex male / female Race_____ Marital Status _____ Employer/Occupation _____

Patient's Employer _____ Work phone _____ ext ____

Parent or Guardian's Names (if Minor) _____ Employers of parents _____

Address (If different from patient's) _____

Spouses name _____ Employer _____

Spouse's work phone _____ ext _____ Spouse's social security #_____

In case of Emergency Contact _____ Phone # _____

Family Physician (PCP) _____ Referred by _____

Person Responsible for Payment _____ Relationship _____

Please give a copy of the insurance card to the secretary for us to photocopy.

Primary holder on insurance: Name _____ SS# _____ DOB:_____

Please read before signing

A copy of the Notice of Privacy Practices is posted for review. Please sign below.

Date _____ Signed _____

I hereby authorize Allergy and Asthma Clinic, PC to release information to my insurance company. I hereby assign and direct payment to Allergy and Asthma Clinic, PC. of the benefits herein specified and otherwise payable to me but not to exceed the doctor's regular charges for this treatment or surgical procedures. I understand I am financially responsible to the corporation for charges/charged amounts not covered by this agreement.

Date _____ Signed _____

Virginia State law provides that when a healthcare worker is exposed to the body fluids of another person in a manner which may transmit human immunodeficiency virus (HIV-the virus that causes AIDS), such as an accidental needle stick, the patient shall be deemed to have consented to the testing for HIV and to the release of the results to the exposed person and to the local health department.

Date _____ Signed _____

By becoming a patient of Allergy and Asthma Clinic, PC. and presenting myself for appointment with the physicians or nurse practitioners, I consent and authorize treatment by the qualified care providers of Allergy and Asthma Clinic, PC. Qualified care providers include but are not limited to the physicians, nurse practitioners, phlebotomists, nurses, etc. I hereby agree that the care providers may examine me, perform non-invasive diagnostic tests and treatment to be performed.

Date _____ Signed _____

We provide telemedicine service via phone and video technology. Like face-to-face medical care, you will be responsible for any co-payments or coinsurance that apply to your visit. I hereby agree for Allergy and Asthma Clinic, PC to provide health care services via phone/video, and I understand that that I will be billed for those health care services if I elect to use them?

Date _____ Signed _____

Allergy and Asthma Clinic, PC **New patient questionnaire**

Patient's name _____ Date of birth: _____ Age _____

For what sorts of problem are you consulting the doctor for today?

_____

_____

When did your condition begin? _____ Have you seen an allergist before? Yes / No Who? _____ When?____
Where skin tests done? Yes / No Did you receive allergy shots? _____

What other medical or emotional problems are you being treated for?

_____

_____

What surgeries have you had? _____

What medications do you take? _____

_____

Do you have any drug allergies? _____

Do you have HIV or AIDS, Hepatitis B, Hepatitis C, or any other blood transmitted disorders? _____

What is your profession? _____ Marital status? ____ Did you ever smoke? Yes / No Do you still smoke? Yes / No
Number of years smoked ____ Year quit ____ Are you exposed to second hand smoke? Yes / No How much alcohol do you drink?_____ Other drugs? _____

Family history of food allergies, allergic rhinitis, asthma? _____

Do you live in: house, apartment, trailer Year built? ____ BASEMENT? None / Damp / Dry What kind of heat do you have?_____ Type of air conditioning? _____ Do you have pets? _____ What kind of pets do you have? _____ Is your bedroom tile, hardwood, carpet ? _____ Dust mite covers? yes / No

Do you have any of the following problems? Please circle all that apply

Constitutional: anorexia, chills, fatigue, fevers, malaise, sweats, weight loss

ENT: ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia (trouble swallowing)

Eyes: blurring, diplopia (double vision), discharge, eye pain, irritation, photophobia, vision loss

Respiratory: cough, dyspnea (shortness of breath), excessive sputum, hemoptysis (cough up blood), wheezing

GI: abdominal pain, change in bowel habits, constipation, diarrhea, hematochezia (blood in stool), jaundice, melena (dark black tarry stool), nausea, vomiting

Cardiovascular: chest pains, palpitations, syncope, orthopnea (trouble breathing when sleeping flat), peripheral edema

Genitourinary: pain on urination, blood in urine, incontinence

Musculoskeletal: arthritis, back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness

Skin/Integumentary: dryness, itching, rash, suspicious lesions

Neurological: paresthesias, seizures, syncope, transient paralysis, tremors, vertigo, weakness

Psychiatric: depression, anxiety, hallucinations, mental disturbance, paranoia, suicidal ideation

I authorize that the information on this page is true to the best of my knowledge.

Signed _____ **Date**_____

Allergy and Asthma Clinic, PC

Medical Information Release Form / HIPPA Release Form

Patient Name:_____ Date of birth:_____

Release of Information

I grant permission to Allergy and Asthma Clinic, PC to disclose my protected health information to the following individual(s). If anyone other than the person(s) listed below should call or ask for information, they will be denied. If I chose not to have my information released to anyone, then I am agreeing that I am the only person that can receive my information. (Check at least one below)

___ Spouse _____

___ Child(ren)_____

___Other _____

___Information is not to be released to anyone.

Please let us know which numbers we can call to reach you

___My home # _____

___My cell number _____

___My work number _____

___Email _____

Please check a box below

____You may leave a detailed message

____Please leave a message asking me to return your call

This Release of information will remain in effect until terminated by me in writing.

Signature

_____ Date: _____

Please Print

_____

Allergy and Asthma Clinic, PC

CONSENT FORM FOR ALLERGY INJECTIONS

Although your hyposensentization program and vaccine have been prepared with the utmost care and precautions, significant reactions may occur after the injection of substances to which you are allergic. Local reactions are common. Reactions may be local swelling, tenderness, and redness. Reactions can be more generalized to include hives, sneezing watery eyes or nose, wheezing or tightness of the chest, hoarseness, and coughing. Generalized reactions occur rarely, but are the most important because of the potential danger of anaphylactic shock which can include, angioedema, collapse, and death. Please let a staff member in the clinic know if you notice any symptoms.

We have thus recommended that injections be given by a trained person in a facility that is equipped to treat anaphylactic reactions under the supervision of a physician. Since most reactions occur with 30 minutes, we require that you remain the clinical area for 30 minutes after the injection. If at any time you do not wait the 30 minutes following your allergy injection, your signature below will releases Allergy and Asthma Clinic, PC and its staff from any medical liability resulting from an anaphylactic reaction.

Some delayed reactions occur after leaving and may need treatment as well. These are seldom emergencies, but may require medical intervention to relieve discomfort and swelling. Take you regular medication and call the office. All reactions must be reported to the medical personnel before receiving your next shot. Describe how severe the reaction was-the size of the swelling by comparing with the size of a coin or piece of fruit.

We require that you notify the office of any change in your health. If you are on a medication for high blood pressure, your heart, or migraine headaches please discuss this with the allergist before receiving allergy injections. Patients on BETA-BLOCKERS should NOT receive allergy shots. Please also notify the physician if there are any changes in your medications while receiving immunotherapy. Notify the physician if you become pregnant on immunotherapy.

I have read and understand the information. I have been given the opportunity to ask questions and am satisfied that my questions have been fully answered. I understand the risks involved with immunotherapy. I consent and authorize to allergy injections and to the treatment of any reactions that may occur.

_____ _____

Patient Signature Date

_____ _____

Parent for Minor Signature Date