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 / HIPAA 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

_____

Christina M. Abraham, MD

Allergy and Asthma Clinic, PC

1117 South Jefferson Street

Roanoke, VA 24016

Telephone: 540-343-1235 Fax: 540-343-6337

PATIENT CONSENT FOR ALLERGY SKIN TESTING

The skin test is a method of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a wheal, swelling, or flare in the surrounding area of redness).

Prick Method: The skin is pricked with a applicator where a drop of allergen has already been placed.
Intradermal Method: This method consists of injecting small amounts of allergen into the superficial layers of the skin.

You will be tested to important airborne allergens or foods. These include, trees, grasses, weeds, molds, dust mite, and animal danders or foods. Prick tests are usually performed on your back, but may also be performed on your arms. Intradermal skin test, if necessary, are performed on your arms.

If you have a specific allergen sensitivity to one of the allergens, a red, raised, itchy bump will appear on your skin within 15-20 minutes. These positive reactions generally disappear within 30 to 60 minutes. Occasionally local swelling at a test site will begin 4 to 8 hours after the skin tests are applied, particularly at sites of intradermal skin testing. These reactions are not serious and will disappear over the next week or so. You may be schedule for skin testing to antibiotics, local anesthetics (caines), venoms, or other biological agents. The same guidelines apply.

Allergic reactions to skin testing are rare. Possible reactions to skin testing include: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and anaphylaxis and shock (sudden, severe generalized allergic reaction), the latter under extreme circumstances.

Please note that these reactions rarely occur but in the event a reaction would occur, the staff is fully trained and emergency equipment and medications are available.

I hereby Christina M. Abraham, M.D. to provide such additional services which may deem reasonable and necessary including, but not limited to, the treatment of severe allergic reaction in a hospital or emergency room, using services of the X-ray department, laboratories or hospitalization and that our office is not responsible for any costs associated with these treatments.

I have acknowledged that I have stopped all antihistamines 5 days prior to this testing as they may interfere with test results. These antihistamines include those by prescription and over the counter. Please let the physician if you are pregnant. Allergy skin testing may be postponed until after delivery.

I hereby state that I have read and understand this consent, and have had all of my questions about the procedure or procedures and treatment answered to my satisfaction.

I authorize Dr. Christina M. Abraham, MD to perform allergy testing if deemed necessary. The above named procedures may not be performed on all patients. No testing or procedures will be performed without my consent.

I have read the patient information sheet on allergy testing and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of allergy skin testing and these questions have been answered to my satisfaction. I understand at every precaution consistent with the best medical practice will be carried out to protect me against such reactions.

THIS CONSENT FORM IS VALID UNTIL REVOKED BY ME IN WRITING!

Print Patient Name: _____Patient Signature: _____ Date: _____

Parent Legal guardian: _____ Physician: _____ Date: _____