Personal Information Sheet

Preferred location for your visit: ☐ Plano ☐ McKinney ☐ Texoma
Patient Name: _____ Date: _____
Date of Birth: _____ Age: _____
Gender: ☐ Male ☐ Female
1. Primary Email of Correspondence: _____
2. Best Phone number to contact you: _____ ☐ Cell ☐ Home ☐ Work ☐ Spouse
3. Alternative Phone number to contact you: _____ ☐ Cell ☐ Home ☐ Work ☐ Spouse
4. Primary Care Physician: First name: _____ Last: _____ City: _____
5. Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Type-Unknown
6. Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Type Unknown Language: _____
7. How did you hear about our practice? ☐ Physician- First and Last name: _____
☐ Friend- Frist and Last name: _____ ☐ Internet Search: _____
☐ Insurance Company listing ☐ Print Ad: ☐ Other: _____
8. Briefly describe the reason for your visit with our office: _____

9. **Current Medication**- Please list any and all Current OTC and Prescription medications that you take regurlarly or as needed for any reason- please indicate drug name, dose and dosing instruction: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
10. Please indicate the local pharmacy you would like for us to send your Rx if needed- please indicate pharmacy name, city, address and phone number:

11. Please indicate the mail-in pharmacy you would like for us to send your long term recurrent Rx if needed- please indicate pharmacy name, city, address and phone number:

12. Please indicate if you prefer liquid or tablet forms of medication if available- ☐ Liquid ☐ Tablet
13. **Past Medical History**- Please list any resolved problems that are no longer active: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
14. **Current Medical Problems**- Please list any active medical problems that have not resolved: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
15. **Past Surgical History**- Please list the type of surgery, date, and surgeons's first, last name: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
16. **Family History**- Please list any close relative(s) (mom, dad, brother, sister) that suffers from any asthma, allergies, skin conditions, autoimmune, and/or immune deficiency states: ☐ None ☐ Unknown
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
17. **Immunization History**-
A. Are your vaccinations up to date: ☐ Yes ☐ No ☐ Unknown If no, please explain why not: _____
B. Have you received this year's annual flu shot? ☐ Yes ☐ No ☐ Unknown If yes- when: _____
C. Have you ever received the Pneumonia/Pneumovax shot? ☐ Yes ☐ No ☐ Unknown If yes- when: _____
18. **Food Allergy**- Please list any **food** allergy/intolerance and the specific symptoms experienced: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
19. **Drug Allergy**- Please list any **drug** allergy/intolerance and the specific symptoms experienced: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
20. **Chemical Allergy**- Please list any **chemical** allergy/intolerance and the specific symptoms experienced: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____

Personal Information Sheet

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Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____

Gender: ☐ Male ☐ Female

21. Insect Allergy- Please list any **insect** allergy/intolerance and the specific symptoms experienced: ☐ None

A. _____ **B.** _____

22. Social History- Please answer the following questions regarding the patient's social status:

1. Do you currently smoke? ☐ Yes ☐ No If yes, how long? _____ yrs

If yes, do you smoke daily? ☐ Yes ☐ No

2. Do you live with someone that smokes? ☐ Yes ☐ No If yes, how long? _____ yrs

3. Do you have a history of smoking in the past? ☐ Yes ☐ No If yes, how long? _____ yrs

4. Are you routinely exposed to animals/pets? ☐ Yes ☐ No If yes, please list the type of animal/pet:

_____

5. Are you exposed to mold? ☐ Yes ☐ No Where? _____

6. Are you exposed to fumes/strong odors? ☐ Yes ☐ No Where/What? _____

7. Are you exposed to chemicals? ☐ Yes ☐ No Where/What? _____

8. Are you routinely exposed to birds/pigeons/dove/fowl? ☐ Yes ☐ No If yes, please list: _____

9. Please note the current occupation of the patient (If Applicable): _____

23. Infection History- Please answer the following questions regarding recent past infections: ☐ None

1. Number of ear infections in the last 12 months: _____ Treated with antibiotics? ☐ Yes ☐ No

2. Number of sinus infections in the last 12 months: _____ Treated with antibiotics? ☐ Yes ☐ No

3. Number of episodes of pneumonia in the last 12 months: _____ Treated with antibiotics? ☐ Yes ☐ No

4. Number of episodes of bronchitis in the last 12 months: _____ Treated with antibiotics? ☐ Yes ☐ No

5. Number of episodes of sore throat in the last 12 months: _____ Treated with antibiotics? ☐ Yes ☐ No

6. Other major infections in your lifetime and approximate date experienced/treated: ☐ None

A. _____ **B.** _____

C. _____ **D.** _____

E. _____ **F.** _____

24. Please list any oral or systemic steroids that you have received in the last year with the approximate date and condition for which the steroids were prescribed for: ☐ None

A. _____ **B.** _____

C. _____ **D.** _____

25. List of antibiotic names used in the last 12 months: ☐ None

A. _____ **B.** _____

C. _____ **D.** _____

E. _____ **F.** _____

26. Review of Systems- Please check any signs/symptoms/conditions that you **currently** experience: ☐ None

Constitutional:	☐ Fatigue	☐ Night Sweats	☐ Chills	☐ Fevers	
Respiratory:	☐ Short of Breath	☐ Wheeze	☐ Cough	☐ Croup	☐ Tight Chest
GI:	☐ Heartburn	☐ Reflux	☐ Vomiting	☐ Diarrhea	☐ Trouble Swallowing
Urinary:	☐ Urinary Infection	☐ Blood in Urine	☐ Back Pain		
Frequent infections:	☐ Sinusitis	☐ Pneumonia	☐ Ear/Throat	☐ Bronchitis	☐ Skin
Musculoskeletal:	☐ Stiff/Sore Joints	☐ Muscle Pain	☐ Red Swollen Joints		
Eyes:	☐ Blurry	☐ Itch	☐ Water	☐ Red	☐ Frequent Infections
Nose:	☐ Runny	☐ Stuffy	☐ Itchy	☐ Sneeze	☐ Loss of Smell
Chest:	☐ Slow Heart Rate	☐ Palpitations	☐ Tight Chest	☐ Chest Pain	☐ Fast Heart Rate
Neuro:	☐ Numbness	☐ Seizures			
Skin:	☐ Dry	☐ Itch	☐ Swelling	☐ Rash	☐ Hives
Hematology:	☐ Unusual Bleeding	☐ Unusual Bruising	☐ Swollen Lymph Nodes		
Endocrine:	☐ Weight Gain	☐ Weight Loss	☐ Increased Thirst	☐ Cold Intolerance	☐ Heat Intolerance
Psychology:	☐ Anxious	☐ Depressed	☐ Stressed	☐ Worried	

Other: _____

_____

_____

27. Any other information you would like to share about your upcoming visit:

_____

_____

_____

_____

Consent: The above information is correct to the best of my ability and accurately reflects my/the patient's current state of health. Please sign below if you agree to this statement.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date completed/updated: _____

Southwest Allergy & Asthma Center

John Van Wagoner, MD, PA

CONSENT FOR USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION
And
RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health Information (PHI) to carry out treatment, payment activities, and healthcare operations (TPO).

Notice of Privacy Practices: Our office promises not to disclose your PHI (name, address, phone number(s), social security number, date of birth, etc.) outside of the TPO without your specific authorization and consent. Our office complies with HIPAA and all federal and state laws regarding the privacy of your information. A copy of our Notice of Privacy Practices document is posted on our website in the helpful links section and a copy is available to you at any time at our office.

You may refuse to sign this authorization.

Acknowledged and agreed to by:

PATIENT or PARENT SIGNATURE _____

Patient Name: _____ Date: _____

Patient DOB: _____

OPTIONAL: Disclosure of Protected Health Information

I understand that any and all medical care that I receive at Southwest Allergy and Asthma Center will be treated with the utmost confidentiality. To facilitate my medical care, I hereby authorize Southwest Allergy and Asthma Center to disclose PHI about my treatment and medical condition to the following individuals:

Name: _____ Relationship: _____

Date of Birth: _____ Phone Number: _____

Name: _____ Relationship: _____

Date of Birth: _____ Phone Number: _____

PATIENT FINANCIAL ADVISORY

NON-COVERED SERVICES

_____(initials) I understand Southwest Allergy and Asthma Center (SWAAC)'s contractual agreement with health care service plans relates only to items and services which are deemed "covered" by the individual health plan. Consequently, I accept full financial responsibility and agree to pay out-of-pocket for all items or services which are deemed "non-covered" by the individual health plan.

HMO REFERRALS

_____(initials) I understand that if my insurance company has designated a primary care physician (PCP), I am required to have prior authorization from my PCP prior to my office visit. If the authorization is not provided, whether by the Guarantor or through the insurance carrier, the Guarantor will be asked to either reschedule the appointment or pay for the visit out-of-pocket at the time of service.

SELF-PAY ACCOUNTS

_____(initials) Self-pay accounts are those (1) with no available health insurance coverage at the time of service or (2) are covered by an insurance carrier with which SWAAC does not participate. I agree to be individually responsible to pay the full charges at the time of service if I have a self pay account.

CHANGES TO COVERAGE

_____(initials) I understand that it is my responsibility to advise SWAAC of any changes with my insurance carrier, to confirm the practice's participation, and my eligibility prior to each visit. I agree to pay the full charges of all services rendered by SWAAC if services are deemed "non-covered."

SERVICES RENDERED

_____(initials) I agree that in return for services provided to the patient by SWAAC, the account balance will be paid at the time service is rendered or I will make appropriate financial arrangements satisfactory to SWAAC for payment. If co-payments, deductibles or co-insurance amounts are designated by a contractual agreement to an insurance provider or health plan, I agree to pay these amounts to SWAAC. I understand and agree that if my account is delinquent, my account may be referred to a third-party agency for collections and fees may apply if such services are utilized. If extenuating circumstances should prevent me from providing payment, I may discuss the matter with a Treatment Coordinator.

- As a courtesy, SWAAC files claims to your insurance provider. If you are covered by insurance, it is your responsibility to understand the provisions under which you are covered.
- Missed or cancelled appointments with less than a 24 hour notice will be subject to a $25 no-show fee.
- A minimum fee of $25 may be assessed to release medical records.
- In the event that a guardian shares custody of a patient, the guardian present at the time of service is responsible for payment in full at that time. If you have a court order requiring treatment costs to be shared, it is the responsibility of the guardians to make appropriate arrangements prior to treatment.
- All returned checks will be assessed a $25 fee.

My signature below indicates I understand and agree to pay in full any balance unpaid by my insurance provider.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date
_____	_____	_____
*Legal Representative's Printed Name	Legal Representative's Signature	Date

_____

If representative, specify relationship to patient

SWAAC
SOUTHWEST ALLERGY & ASTHMA CENTER

Confidential Voicemail Authorization

- Occasionally, it may become necessary to contact our patient(s) by telephone. In the event you are not available by phone, we will leave detailed voicemail messages regarding your/your child's treatment. By providing your telephone number(s), you hereby grant SWAAC permission to leave detailed voicemail messages regarding your/your child's treatment.

- o **My cell phone:** _____
- o **My Home phone:** _____
- o **Family Member** _____
- o **Other (name)**: _____

Phone Number: _____ **Phone Number:** _____

- o I do not wish to receive voicemail messages regarding my/my child's treatment.

Text/E-Mail Messaging Authorization

- To better serve you, we utilize text and/or email messaging for appointment reminders and important announcements. By providing your mobile number(s) and email address, you hereby grant SWAAC permission to contact you regarding appointment reminders and important announcements.

E-Mail:_____**Cell:**_____

- o I do not wish to receive text messages regarding appointments and important announcements.
- o I do not wish to receive emails regarding appointments and important announcements.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date
_____	_____	_____
*Legal Representative's Printed Name	Legal Representative's Signature	Date

_____
**If representative, specify relationship to patient*