Follow Up Patient Packet

Established Patient Update

1. Patient Name: _____ Date of Birth: _____

   Gender:
   ○ Female ○ Male

   Primary Email: _____

   Primary Phone: _____

   Primary Care Physician First Name: _____

   Primary Care Physician Last Name: _____

   Primary Care Physician City: _____

   Height: _____ Weight: _____

2. **If Patient is a minor please provide both parents full names below:**

   Father's First Name: _____ Father's Last Name: _____ Mother's First Name: _____ Mother's Last Name: _____

3. **Briefly describe the MAIN REASON(S) for this visit:**

   _____

   _____

   _____

   _____

4. **Please describe the MAIN OUTCOME you would like to obtain from this visit with our Allergy/Asthma/Immunology Specialist.**

   _____

   _____

   _____

   _____

5. **Do you currently take any prescription medications?**

   ☐ Yes ☐ No

6.

	Medication	Dosage/Frequency	Reason for Use
1			
2			
3			

7. Do you currently take any over-the-counter (OTC) medications regularly or as needed?

☐ Yes ☐ No

8.

	Medication	Dosage/Frequency	Reason for Use
1			
2			
3			

9. Do you currently have any specific FOOD allergies/intolerances?

☐ Yes ☐ No

10.

	Food Allergy/Intolerance	Symptoms Experienced
1		
2		
3		

11. Do you currently have any specific DRUG allergies/intolerances?

☐ Yes ☐ No

12.

	Drug Allergy/Intolerance	Symptoms Experienced
1		
2		
3		

13. Do you currently have any specific INSECT/CHEMICAL allergies/intolerances?

☐ Yes ☐ No

14.

	Insect/Chemical Allergy/Intolerance	Symptoms Experienced
1		
2		
3		

15. Have you received a flu vaccination for the current flu season?

○ Yes ○ No

○ Unknown

16. Have you received a Covid 19 shot this year?

- ○ Yes
- ○ No

17. If yes, please specify date:

_____

18. If yes, please specify date:

_____

19. Have you ever received the pneumonia shot called Pneumovax?

- ○ Yes
- ○ No
- ○ Unknown

20. If yes, please specify date:

_____

21. Have you ever received the pneumonia shot Prevnar 13?

- ○ Yes
- ○ No
- ○ Unknown

22. If yes, please specify date:

_____

23. Please indicate your preferred local Pharmacy:

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

24. Please indicate if you prefer liquid or tablet forms of medication, if available:

- ○ Liquid
- ○ Tablet

25. Please list any NEW information regarding your health since your last visit: (Indicate recent surgeries, illnesses, new diagnoses, etc:)

_____

_____

_____

_____

26. Have you had any changes in your social status since your last visit (job, residence, tobacco/alcohol use/ allergen exposure)?

- ○ Yes
- ○ No

27. Please specify:

_____

_____

_____

_____

28. Have you had any changes in your Family History since your last visit (relative with new illnesses or disease)?

- ○ Yes
- ○ No

29. Please specify:

_____

_____

_____

_____

30. Review of Systems: Please check any signs/symptoms/conditions that you currently experience:

Constitutional:
☐ Fatigue ☐ Night Sweats ☐ Fevers

Respiratory:
☐ Shortness of Breath ☐ Wheeze ☐ Cough ☐ Croup ☐ Tight chest

GI:
☐ Indigestion ☐ Reflux ☐ Vomiting ☐ Diarrhea ☐ Trouble Swallowing

Urinary:
☐ Urinary Infection ☐ Blood in Urine ☐ Back Pain

Frequent Infections:
☐ Sinus ☐ Lung ☐ Ear/Throat ☐ Bronchitis ☐ Skin

Musculoskeletal:
☐ Stiff/Sore Joints ☐ Muscle Pain ☐ Red Swollen Joints

Eyes:
☐ Blurry ☐ Itch ☐ Water ☐ Red ☐ Frequent Infections

Chest:
☐ Slow Heart Rate ☐ Palpitations ☐ Tight ☐ Chest Pain ☐ Fast Heart

Nose:
☐ Runny ☐ Stuffy ☐ Itchy ☐ Sneeze ☐ Loss of Smell ☐ Loss of Taste

Neuro:
☐ Numbness ☐ Seizures

Skin:
☐ Dry ☐ Itch ☐ Swelling ☐ Rash ☐ Hives

Psychology:
☐ Anxious ☐ Depressed ☐ Stressed ☐ Worried

Hematology:
☐ Unusual Bleeding ☐ Unusual Bruising ☐ Swollen Lymph Nodes

Endocrine:
☐ Weight Gain ☐ Weight Loss ☐ Increased Thirst ☐ Cold Intolerance ☐ Heat Intolerance

My signature indicates that the above information is accurate to the best of my knowledge.

Patient/Guardian

_____

Signature

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: This office will not 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. This office complies with HIPAA and all federal and state laws regarding the privacy of your information. The Notice of Privacy Practices is available on our website under Education. A printed copy is also available upon request.

You may refuse to sign this authorization.

Acknowledged and agreed to by:

PATIENT/GUARDIAN SIGNATURE	PATIENT NAME	PATIENT DOB

DATE COMPLETED/UPDATED

OPTIONAL: Disclosure of Protected Health Information

I understand that any and all medical care that I receive at Southwest Allergy & Asthma Center will be treated with the utmost confidentiality. To facilitate my medical care, I hereby authorize Southwest Allergy & Asthma Center to disclose PHI regarding 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. Excessive No-Shows will result in a non-refundable deposit prior to scheduling.
- 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*