Allergy Institute, P.C.

NEW PATIENT INFORMATION – Please print or write clearly and fill in all blanks.

Today's Date: _____/_____/_____ **Account Number (For Office Use Only):_____**

Patient's Legal Name: _____ Sex: _____ Date of Birth: ____/____/_____
Last First MI

Address: _____
Street Apt # City State Zip

SS# _____-_____-_____ Employer: _____Student Status (if applicable): Full Time or Part Time

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____ Email:_____

How did you hear about our clinic? _____Our Website _____ Friend Media / Other Source: _____

Referring Physician: _____ Address: _____

Race: Caucasian, African-American, Asian Native American, Pacific Islander (Circle)

Ethnicity: Hispanic, Latino or Non-Hispanic (Circle)

Marital Status: (S M W D) (Circle)

Person Financially Responsible For Bill: _____ Relationship to Patient: _____
(If same as above, skip to the insurance)

Their SS# _____-_____-_____ Their Date of Birth: _____/_____/_____ Martial Status (S M W D) Sex: _____

Their Home Address: _____
Street Apt # City State Zip

Employer: _____Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

INSURANCE INFORMATION

****** If you have a copy of your card and you are the policy holder you can skip the insurance portion below******

Primary Insurance Name: _____ Relationship to Patient: _____

Policy ID No: _____ Policy Group No: _____ Policy Holder's Date of Birth: _____/_____/_____

Policy Holder's Name: _____Employer: _____

Policy Holder's Home Address: _____
Street Apt# City State Zip

Secondary Insurance Name: _____Relationship to Patient: _____

Policy ID No: _____ Policy Group No: _____Policy Holder's Date of Birth:_____/_____/_____

Policy Holder's Name: _____Employer: _____

Policy Holder's Home Address: _____
Street Apt# City State Zip

Updated 4/2023

Allergy Institute, P.C.

Patient Name:_____ Date of Birth:_____

Phone No:_____ Email:_____

☐ I authorize the Allergy Institute to leave voice mail messages on the number listed above regarding my healthcare and laboratory results.

☐ I **DO NOT** authorize the Allergy Institute to leave voice mail messages on the number listed above regarding my healthcare and laboratory results.

Emergency Contact Information

Name:_____ Relationship:_____ Phone No: _____

Name:_____ Relationship:_____ Phone No:_____

☐ I authorize this individual(s) to receive information regarding my appointments/medical care.

☐ I **DO NOT** authorize this individual(s) to have information regarding appointments/medical care.

Release of Information to Other Medical Provider(s)

I authorize my office notes and all testing results be sent to the the following medical provider(s):

Provider Name:_____ Name of Clinic:_____

Provider Name:_____ Name of Clinic:_____

Release of information to Insurance Companies, Financial Responsibility & Acknowledge of Privacy Practices

By signing below, this will allow the Allergy Institute to expedite the insurance claims for services provided by our providers and to disclose information to the insurance companies regarding my health and treatment. I hereby authorize the release of any medical information necessary to process the health insurance claims for services provided by the Allergy Institute.

By signing below, I understand that I am financially responsible for all services provided. The Allergy Institute will process claims through my insurance but I understand I am financially responsible for any outstanding balance not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for the coverage(s) provided by my health insurance carrier(s) to the Allergy Institute and direct payment of proceeds be made directly to the Allergy Institute.

_____**By signing below, I understand that I will be responsible for any missed appointments in which a 24 hour notice was not given. There will be a $25.00 fee for any missed standard office visits. There will be a $50.00 fee for any missed office visits with scheduled testing or procedures.**

By signing below, I acknowledge that the Allergy Institute's Privacy Practice Rights has been made available to me if requested. I acknowledge that access to this document is available upon request. I understand that I have the right to change or revoke this information at any time.

Patient/Legal Guardian Signature:_____ Date:_____

ALLERGY INSTITUTE, P.C. **Date: _____**

Medical History Form

First Name_____ Middle Name_____Last Name_____
Birth Date:___/___/___ Occupation_____

Do you have an advance directive or living will? Yes☐ No☐ Do we have a copy? Yes☐ No☐
Primary Care Provider: _____ Preferred Pharmacy:_____
Referring Provider: _____ Location: _____
Allergies to medications? _____
Any other allergies?_____

See attached medication list ☐

Medication	Dose	Medication	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous Therapy

Have you seen ENT Yes/No_____
Have you seen an allergist before Yes/No_____
How long have your symptoms been going on? _____ months _____ years
Are you taking allergy medication? Yes/No_____
Have you been off your allergy medication? Yes/No_____
What medication/therapy have you tried? _____
Have you had relief from alternate therapy? Yes/No_____
When are your symptoms worse? Spring, Summer, Winter, Fall, all year round
Do your symptoms occur at the same time every day? Yes/No_____

Environmental History
(Check those that apply)

Live in a house ☐
Live in an apartment ☐
Animals in home or exposure ☐
Exposure to mold ☐
Cockroaches in home ☐
Live near corn field ☐
Second hand smoke in home ☐

Social history

Tobacco products ☐
Alcohol use ☐
Caffeine Use ☐
Currently on a "special diet ☐
Drug use ☐
Exercise regularly ☐

Surgery/Hospitalization

Sinus surgery ☐
Tonsils & Adenoids removed ☐
Ear Surgery ☐
Other:
_____
_____
_____

Personal

ER visit for lung problems ☐
Hospitalized for lung problems ☐
Tonsillectomy/Adenoidectomy ☐
Allergies ☐
Anaphylaxis ☐
Asthma ☐
Cancer ☐
Coronary Artery Disease ☐
Diabetes ☐
Gastric Reflux ☐
Heart disease ☐
High cholesterol ☐
High blood pressure ☐
Nasal polyps ☐
Other ☐

Family History

No significant family history ☐
Family history unobtainable ☐
Allergies ☐
Asthma ☐
Angioedema ☐
Cancer ☐
Depression ☐
Diabetes ☐
Heart disease ☐
High blood pressure ☐
Stroke ☐
Other family history ☐
_____
_____
_____