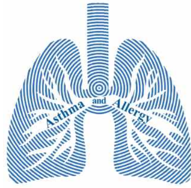



**ASTHMA & ALLERGY CENTER**

Parkersburg. Ripley.Beckley.Logan.
CHARLESTON . WV 25314
**Asthmaweb,com**
304.343.4300

# Welcome

All of us at the Asthma and Allergy Center would like to welcome you as a new patient to our office. Please read the Office Policies Brochure, fill in all six pages of the New Patient Registration & Medical History Form, and bring it with you on your first visit. If you have received this packet in mail and prefer to fill the form on a computer, you'll find it on the New Patient Page of our website: **asthmaweb.com**. Please print the filled form and bring it with you*.

You will need to stop taking any medications that contain antihistamines [such as Claritin, Benadryl, Clarinex, Zyrtec etc.] for a minimum of five days prior to your visit. If your appointment is less than five days away, or you cannot stop the Antihistamines due to severe symptoms, or you are not sure whether the medications you are taking contain anAntihistamine **, please call us. You must not stop any other medications you are on that do not contain antihistamines.

Please note that a new patient office visit can take up to three hours depending on thetests you may need.

If your insurance requires referral to see a specialist please ensure it is obtained prior to your visit date. If you need help with that or have questions about any other aspect of your visit please feel free to call us at **304-343-4300.**

We look forward to serving you.

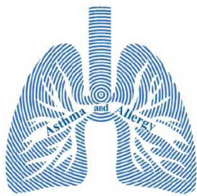
Sincerely yours

Asthma and Allergy Center

*Besides the completed forms, please bring your Govt. issued photo ID (of the responsible person if other than the patient), health insurance and prescription cards, bottles of current medications if you are on more than two or three, and any referral documents or test reports your doctor may have given you.

**Many prescription and over the counter medications for cough, colds, allergies, sinus, sleep, mental health, vertigo, motion sickness, nose sprays, eye drops etc. contain antihistamines.

This page intentionally left blank




# ASTHMA & ALLERGY CENTER

208 MacCorkle Ave. SE, Charleston, WV 25314
Charleston.Beckley.Parkersburg. Ripley.Logan.Montgomery
Asthmaweb.com
304.343.4300

Patient's Name________________________ Age_______ Birthdate______________ ☐ Male ☐ Female

Race/Ethnicity: Caucasian African-American Asian-American Hispanic Native -American Other: _________

Address________________________________________ City__________________State______ Zip _________

Home Phone______________________ Cell Phone ____________________ S.S. #______________________________

Employer__________________________________ Work Phone________________ Email:_____________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Student ? ☐ yes ☐ no

Spouse's Name________________________________Spouse's Employer:____________________________________

Spouse's Work Phone _________________ Spouse's Work Address:________________________________________

Are any family members patients here? ☐ no ☐ yes. If yes, who?____________________________________________

Name and address of a close relative not living with you: Name_____________________________________________

Address ______________________________________________ Home Phone ______________________________

**IF PATIENT IS A MINOR:**

Mother's Name________________________ Employer_______________ Work Phone_____________ Cell___________

Father's Name________________________ Employer_______________ Work Phone_____________ Cell___________

Legal Guardianship: ☐ Parents ☐ Mother Only ☐ Father Only ☐ Other: ______________________________________

**REFERRING PHYSICIAN / PCP INFORMATION:**

Doctor who referred for consultation:__________________________ Tel No.____________ Location:________________

Patient's Primary Care Physician:_____________________________ Tel No.____________ Location:________________

**PRESCRIPTION CARD INFORMATION:**

| | **Company Name** | **Card I.D. No.** | |
|---|---|---|---|
| 1st | _______________________ | _______________________ | **Your Pharmacy Name:** ______________________ |
| 2nd | _______________________ | _______________________ | **Location:**______________ **Tel No:**______________ |

**HEALTH INSURANCE**: (You MUST bring your insurance cards with you.)

**1st Company Name**: _____________________ Policy No. _____________________ Eff Dates: from_______ to________

Policyholder Name & D.O.B.___________________________ _________ SS#:_______________ Rel to Patient:_______

Address :__________________________________ Home #:____________ Work #:____________ Cell #:_____________

**2nd Company Name**:_____________________ Policy No.______________________ Eff Dates: from_______ to________

Policyholder Name & D.O.B.___________________________ _________ SS#:_______________ Rel to Patient:_______

Address :__________________________________ Home #:____________ Work #:____________ Cell #:_____________



**continued** →

Does your insurance require referral or pre-certification to see a specialist? ☐ no ☐ yes ☐ don't know

Is treatment of allergies covered by your Insurance? ☐ no ☐ yes ☐ don't know

How much is your deductible? $__________. Is it ☐ yearly? ☐ half yearly? Is it ☐ per person? ☐ whole family?

Have you met your deductible for this year? ☐ no ☐ yes In which month does your deductible restart?___________

How did you learn about us?____________________________________________

**PAYMENT & BILLING POLICIES**

For Medicare, Medicaid and insurance programs that list us as preferred provider, you are responsible only for the deductible and copayments, **which must be paid at check out time**. We will submit and follow up the insurance claims.

For all other insurance policies, the deductible, copayment and coinsurance **must be paid at check out time**. We will submit your insurance claim if you wish, but you must follow up with your insurance company. In all cases you are responsible for whole or any part of the bill not covered by insurance.

If you are unable to pay as above at check out time, **please call in advance or see the receptionist before you see the doctor** to make alternate arrangements.

We accept Visa / MC / Discover.

**CONSENTS:**

**With respect to the patient described on this form, for services performed by any medical provider at or on behalf of Asthma and Allergy Center, I agree and give my consent as follows:**

1. To conduct medical tests and give medical treatment as per the provider's best judgment.
2. Use this form as authority to submit bills and receive payments from my Health Insurance Companies.
3. To release any or all information and to send medical reports to my Health Insurance Companies, the referring doctor, the primary doctor and any other doctor treating the patient and as described in the Privacy Notice I have received, read and reviewed.
4. To contact me by telephone, email or text messages and leave messages on answering machine for test results, missed appointments and appointment reminders at telephone numbers and email addresses given above.
5. To act as my agent in obtaining payment for services performed and prior authorizations from Health Insurance companies; and to use a copy of this authorization in place of original.

7. That I know and understand the benefits, limitations and risks of medical care by Telehealth Visits and give my informed consent to receive care by audio or audiovisual connections. I understand that I can request care by an office visit anytime as an alternative.
8. That I have read, understood and agree to abide by the above statements including those about the billing and payment policies.

I AFFIRM that all information given in these forms is true to the best of my knowledge and that I have legal authority to give these consents and information on behalf of myself or (Patient Name): ________________________

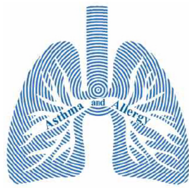
Signature of responsible person_____________________________ Date:_______________ Witness:__________________________

Address: ___________________________________________ SS # ____________________ Driver's Lic No. __________________

**FOR OFFICE USE ONLY**

☐ Written consultation request / Fax response on file ☐ Awaiting fax response

☐ Privacy Notice given ____________________ (initials & date)




# ASTHMA & ALLERGY CENTER

208 MacCorkle Ave. SE, Charleston, WV 25314
Charleston.Beckley.Parkersburg. Ripley.Logan.Montgomery
Asthmaweb.com
304.343.4300

## NEW PATIENT HISTORY

Pt. Name.:________________

If form NOT FILLED BY Patient, Enter Name and Relationship of person who filled the form:

For what illness are you seeking treatment:

D.O.B.: ________________

Check Major Symptoms: (If none, please **Check None**)

| | | | |
|---|---|---|---|
| NOSE: | Itching | Running | Sneezing |
| | Stuffiness | Nosebleeds | None |
| EYES: | Itching | Watering | Swelling |
| | Redness | Dark Circles | None |
| EARS: | Itching | Blocking | Infections |
| | Fluid in Ears | Hearing Loss | None |
| THROAT: | Itching | Voice Loss | Infections |
| | Hoarseness | Post-Nasal Drip | None |
| CHEST: | Coughing | Wheezing | Smothering |
| | Shortness of Breath | Tightness | Infections |
| | Green/Yellow Sputum | Blood in Sputum | None |
| HEADACHE: | Sinus | Facial Pain | Tension |
| | Migraine | Other | None |
| SKIN: | Hives | Eczema | Swelling |
| | General Itching | Rash | None |
| ABDOMEN: | Nausea | Cramps | Vomiting |
| | Indigestion | Diarrhea | None |
| GENERAL: | Fatigue | Feel Sick | Infections |
| | Weight Loss | Poor Appetite | None |

Which of the above are most important to you?

Which of the above are currently bothering you? And for how long?

When did these problems occur for the first time in your life?

Are your symptoms: Constant? In attacks? Seasonal?
Recently getting worse? Explain:

Are you worse in: Jan. Feb. March April May June
July Aug. Sept. Oct. Nov. Dec.

If attacks: How often do you have them?
How long does each last?
When did you have the last one?

Do you have symptoms all year round? n y

Which is your worst season? Spring Summer Fall Winter
All year round

If seasonal or in attacks, are you completely clear of symptoms between spells? n y Explain:

==================================

***Space Below is For Provider's Notes Only***

**Chief Complaint(s) & Duration:**

Initials:__________MD/PAC

Pt. Name:________________

*This space is for physician's notes*

How many chest "colds" do you average per year? Explain:

Do you cough, wheeze, feel tight in the chest, or short of breath after exercise? n y Explain:

Do you cough, smother or wheeze at night? n y

Check any of the following that cause or increase your symptoms:

| | | | |
|---|---|---|---|
| House dust | Flowers | Aspirin | Common Cold |
| Trees | Industrial Fumes | ACE Inhibitor | Air Conditioner |
| Feathers | Weather Change | Beta Blockers | Excitement |
| Weeds | Outdoors | Ibuprofen | Insect Stings |
| Animals | Food Odors | | Exertion |
| Grass | Paints, Varnishes | Beer/Wine | Laughing |
| Hay/Grain | Soaps/Detergents | Cocktail Shrimp | Dampness/Rain |
| Mold/Mildew | Cigarette Smoke | Potato Chips | Fatigue |
| | Cosmetics, perfumes | Salad bar | Cold Air |
| | Insecticides | Other foods | Menstrual Period |
| | | | Temp Change |

Are there any foods you cannot eat for reason other than taste? n y
If yes, which foods and why?

Have you had an unusual or severe reaction to insect stings? n y
Explain:

What treatment have you tried for this illness?

What helped the most?

Do you use nose spray? n y Name of spray?

Have you ever taken oral steroids (Prednisone, Medrol, etc.)? n y
Explain:

When was the last time you had a chest x-ray? Sinus x-ray? TB test?
What were the results?

Have you had allergy tests before? n y When?
By whom?

What were the main positive reactions?

Did you receive "allergy injections"? n y
Did they help? n y

If applicable, are you pregnant? n y BirthControl? n y

If child, is he/she up-to-date on immunizations? n y

Have you ever had pneumonia vaccine? n y Flu vaccine? n y

Is patient or any family member allergic to Penicillin or Cephalosporin? n y
Explain:

Initials:___________MD/PAC

## ENVIRONMENTAL HISTORY

Pt. Name:________________

*This space is for physician's notes*

How many beds in patient's bedroom?

Are there feather pillows in the house? n y

Plastic covers on mattress and pillows? n y

Mattresses are: Innerspring Waterbed Cotton Polyfoam Other

Carpeting in bedroom? Rug Pad?

Drapes? Upholstered Furniture?

Stuffed Animals? Type of Heating System?

Air Conditioning? Electronic Filter?

Do you have pets or other animals around the house? n y

What kind?

In or out of the house?

Is the area around your house damp or moldy? n y
Explain:

Is there any mold or mildew growth inside your house? n y
Explain:

Is there anything else around the house you suspect of causing your symptoms? n y Explain:

Are there any special dusts or fumes where you work? n y
Explain:

**Tobacco Use**:

Never smoked or less than 100 cigarettes in lifetime

Current non-smoker: smoked for _____ years average ____ packs/day
quit _____ months/years ago

Current smoker: 1-3 cig/day ½ -1 pack/day 1-2 packs/day

Non-smoker but exposed to second-hand smoke at home or elsewhere?

Do you use smokeless tobacco? n y

**PAST ILLNESSES: Has patient ever had any of the following?**

| | | |
|---|---|---|
| Asthma | Nasal Polyps | Adenoidectomy |
| Hives | Bronchitis | Sinusitis |
| Tubes In Ears | Welts | Pneumonia |
| Ear Infections | Sinus Operation | Eczema |
| Hay Fever | Tonsillectomy | Nasal Surgery |
| Dermatitis | High Blood Pressure | Diabetes |
| Heart Disease | Tuberculosis | Peptic Ulcer |
| Liver Disease | Hiatal Hernia | Kidney Disease |
| Gastric Reflux | Leg Vein Thrombosis | Arthritis |

Any other Illnesses**:** Explain:

**FAMILY MEDICAL HISTORY (check if yes)**

Have any BLOOD RELATIVES OF THE PATIENT had any of the following?

| | | | |
|---|---|---|---|
| Bronchial Asthma | Hives | Migraine | Food Allergy |
| Emphysema | Hay Fever | Sinus | Eczema |
| Nasal Polpys | Bronchitis | Other Allergies | |

Initials:___________MD/PAC

Pt. Name:________________

*This space is for physician's notes*

Please list all H**ospitalizations** with approximate dates and diagnosis.

| | Reason | Date |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

List all S**urgeries** with approximate dates and diagnosis.

| | Surgery | Date | Diagnosis |
|---|---|---|---|
| 1 | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

List all C**urrent Medical Problems** other than those you are coming to see us for, with approximate date and treatment you are taking.

| | Problem | Date of Diagnosis | Treatment |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

List all C**urrent Medications** you are taking, including supplements and herbals with approximate dates when started. If more than two, pl bring all current bottles with you.

| For Allergic Rhinitis / Asthma: | Date Started |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

| For other illness: | Date Started |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

Are there any **medications you are allergic to or cannot tolerate** for other reasons? n y

List all and explain:

1.

2.

3.

4.

Provider's Signature: . . . . . . . . . . . . . . . . . . . . .

Name in Block Letters: . . . . . . . . . . . . . . . .MD / PA-C

Date: . . . . . . . . . . . . . . . . . . .