PATIENT REGISTRATION FORM

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(*PLEASE PRINT CLEARLY IN BLACK INK*)
** This form must be completed in its **entirety**, so please fill-in **ALL** information to avoid delays**

Today's Date: _____ (Month/Day/Year) E-mail: _____

Patient Name: _____ (Last) (First) (Middle Initial)

Address: _____ (Street) (Apt) (City, State, Zip)

Date of Birth: _____ (Month/Day/Year) Age: _____ Sex: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ W ❑ D

Home #: (_____) _____ ❑ Work #: (_____) _____ ext. _____ ❑ Cell #: (_____) _____ ❑

(Please indicate [√] which phone number above we should use as your primary contact number)

❑ Consultation letters can ONLY be sent to the listed providers with a written order from them for your initial appointment.

Primary Care Physician: _____ (Name) (Address) (Phone)

Referred by: _____ (Name) (Address) (Phone)

Are any members of your family patients of Allergy & Asthma Consultants? ❑ Yes ❑ No _____ (Name)

Guarantor for balances: _____ (Name) (Phone)

Spouse / Parent / Guardian _____ (Relation to patient if not self) (Address)

Primary Insurance: _____ Group & ID #: _____/_____

Claims Address: _____

Policy Holder Name: _____ *Date of Birth: _____/_____/_____

Policy Holder Address: _____ Relation: Self / Parent / Spouse

Secondary Insurance: _____ Group & ID #:_____/_____

Claims Address: _____

Policy Holder Name: _____ Date of Birth: _____/_____/_____

Policy Holder Address: _____ Relation: Self / Parent / Spouse

~ We will require a copy of all valid insurance cards to submit your claims ~

I hereby authorize my insurance benefits to be paid directly to the above-assigned physicians for todays and all future services. I understand that I am responsible to pay any non-covered services. I hereby authorize the release of pertinent medical information to my insurance carrier(s) and listed Primary and/or Referring physicians.

X_____ _____
Patient or Guarantor Signature Date

THANK YOU FOR CHOOSING ALLERGY & ASTHMA CONSULTANTS, LTD.

TURN OVER and complete Allergy Survey

Version Date: 06/16/2021

ALLERGY SURVEY

Patient Name:_____ Date of Birth: _____ Today's Date: _____

Please complete this allergy information survey by circling or underlining applicable conditions.

Reason for this appointment - current complaint/symptoms: _____

_____

EYES: itching burning tearing swelling redness discharge

EARS: itching fullness popping frequent infections draining
Tubes? ❑ Yes ❑ No If Yes, Date: _____

NOSE: itching blocked sneezing running nosebleeds snoring mouth breathing decreased smell
frequents colds polyps (Date of last sinus CT scan: _____)

THROAT: sore mucous post-nasal discharge itching hoarseness
Tonsil & Adenoid Removal? ❑ Yes ❑ No If Yes, Date: _____

CHEST: cough wheeze pain tightness sputum (color _____ amount _____)
shortness of breath: at rest after exertion (Date of last chest x-ray: _____)

SKIN: rash eczema hives swelling itching dry

G-I: nausea cramping gas diarrhea vomiting weight loss difficulty swallowing heartburn

HEAD: headache dizziness lightheaded pressure vertigo

GENERAL: fatigue fever tension sweats chills insomnia

PAST HISTORY: asthma hay fever eczema hives insect allergy sinus infections pneumonia ear infections bronchitis croup
Please list all known food, drug and animal allergies:
_____

SOCIAL HISTORY: Tobacco Use - ❑ Never ❑ Previously, but quit ❑ Packs Per Day _____for _____ years
-Are you exposed to smokers? ❑ Yes ❑ No
Alcohol use - ❑ Never ❑ Occasionally ❑ Daily Type _____
Drug use - ❑ Never ❑ Occasionally ❑ Daily Type _____
Current medications: Please list all current medications including OTC medications (Use separate sheet if necessary)
_____

Previous allergy medications including OTC medications? ❑ Yes ❑ No
If Yes, Drug names & Dates of use:_____
Previous treatment by an allergist? ❑ Yes ❑ No
If Yes, Dates _____ Dr. _____ Address _____
Previous allergy injections? ❑ Yes ❑ No
If Yes, Dates _____ Dr. _____ Address _____
Past major illnesses & Dates: _____
Past major hospitalizations & Dates: _____

When do symptoms occur?: spring summer fall winter morning night day indoors outdoors
exertion weather change emotions old-leaves hay lakeside barns summer home basement attic
lawn-mowing animals alcohol air conditioning heat dampness/humidity cold
perfumes chemicals paints hairspray tobacco ozone insecticides newsprint cosmetics latex
Do symptoms occur after eating? ❑ Yes ❑ No If Yes, please list all known or suspected foods:
_____

FAMILY HISTORY: Any family members with allergies or asthma? ❑ Yes ❑ No If Yes, please indicate.
❑ Father ❑ Mother ❑ Sister(s) ❑ Brother(s) ❑ Grandparent(s)

ENVIRONMENT: Occupation _____ List work exposures, if any _____

Recreation & hobby exposure list _____

Pets/Animals: ❑ Dog(s) ❑ Cat(s) ❑ Bird(s) ❑ Other(s) _____

Bedroom exposures: quilts comforters drapes blinds wall hangings books stuffed animals shutters
air conditioner humidifier air cleaner
Pillow: ❑ Synthetic ❑ Feather Carpet in Bedroom? ❑ Yes ❑ No
Bedroom heat type: Forced Air / Baseboard / Radiator Any stuffed bedroom furniture? ❑ Yes ❑ No

FOR OFFICE USE ONLY: Reviewed by _____ Date _____

Allergy & Asthma Consultants, LTD

Version Date: 07/23/2019