PATIENT INFORMATION FORM

PATIENT INFORMATION: (Please Circle) Minor Single Married Divorced Widowed

Last Name:_____ First:_____ M.I._____ Sex: M/F

Social Security #_____ Date of Birth: _____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

Mailing Address: _____ City:_____ State:_____ Zip:_____

Home # _____ Cell #_____ Work #_____

Name of Employer:_____ Email Address:_____

POLICY HOLDER INFORMATION: (If different from Patient) Single Married Divorced Widowed Separated

Last Name:_____ First:_____ M.I._____ Sex: M/F

Social Security #_____ Date of Birth:_____ Driver's License #_____

Address:_____ Home #:_____ Cell #:_____

Name of Employer:_____ Phone:_____

SPOUSE INFORMATION: (If different from above)

Last Name:_____ First:_____ M.I._____ Sex: M/F

Social Security #:_____ Date of Birth:_____ Driver's License #:_____

Address:_____ Home#_____ Cell #:_____

GENERAL INFORMATION:

Family Physician Name:_____ Phone:_____

Nearest Relative(not living with you) _____ Phone:_____

Incase of Emergency Notify:_____ Phone_____ Relationship:_____

INSURANCE INFORMATION:

Who referred you to our office? (Doctor/Friend/Phonebook)_____ Phone:_____

Primary Insurance Plan:_____ Policy Holder's Name:_____

ID#:_____ Group#_____ Phone:_____

Secondary Insurance Plan:_____ Policy Holder's Name:_____

ID#:_____ Group#:_____ Phone:_____

HIPAA INFORMATION: Instructions for the office when returning phone calls or reminding you about appointments.

I authorized the office to contact me at: [ ] Home [ ] Work [ ] Cell [ ] EMail and May leave messages at: [ ] Home [ ] Work [ ] Cell.

I authorize the office to leave detailed messages about appointments/phone calls: [ ] YES [ ] NO

If you prefer us to leave messages with a specific individual please list them below:

1._____ 2._____ 3._____

INDICATE ANY SPECIAL REQUESTS, IF ANY:_____

E-Mail Address:_____

Patient (or Parent/Guardian) Signature:_____ Date:_____

PATIENT NAME: _____ **DATE:** _____

SYMPTOMS

( ) Sneezing
( ) Blocked Nose
( ) Runny Nose
( ) Watery Eyes
( ) Post Nasal Drip
( ) Itching of the Nose
( ) Itching of the Eyes
( ) Itching of the Mouth/Throat
( ) Swelling of eyelids
( ) Swelling of the tongue/lips
( ) Swelling of the body
( ) Hives
( ) Skin Rash or Eczema
( ) Shortness of Breath
( ) Chest Congestion
( ) Coughing
( ) Wheezing
( ) Headaches
( ) Fatigue
( ) Nausea
( ) Diarrhea
( ) GERD
( ) Stomach Cramps

GENERAL INFORMATION

- What age did these symptoms first occur?

- How often do these symptoms occur and how long do they last?

- How severe are symptoms?

- Does any member in the household or a regular visitor smoke?

- Are you pregnant?

-- How many months?

MEDICAL HISTORY

Have you had:

( ) Hay Fever
( ) Croup
( ) Bronchitis
( ) Asthma
( ) Hives
( ) Skin Rashes
( ) Sensitivity to Foods
( ) Sensitivity to Drugs
( ) Sensitive to Insect Stings/Bites
( ) Skin/Allergy testing
( ) Allergy Shots
( ) Herbal Therapy or Acupuncture
( ) Others: _____

_____

_____

FAMILY HISTORY

Do any of these family members **have allergies**:

( ) Mom ( ) Dad
( ) Brother ( ) Sister
( ) Grandparents
( ) Other relatives

* List any other conditions that run in your family (diabetes, high blood pressure. etc.)

_____

_____

HOME ENVIRONMENT

Do you have:

( ) Central Air Condition
( ) Window A/C Units
( ) Gas Furnace
( ) Electric Furnace
( ) Basement
( ) Carpeting
( ) Allergy Relief Bedding
( ) Air Purifier
( ) Plants

* *Do you have a*:

( ) Cat ( ) Dog ( ) Bird
( ) Other _____

MEDICATIONS

List allergy prescriptions or allergy over the counter medications you are currently on:

_____

_____

_____

_____

_____

List **all other** prescriptions or over the counter medications you are currently taking:
(if you have multiple please provide a copy for our records)

_____

_____

_____

_____

* Medications you have taken in the last year for **allergies or asthma** that is not on current list: _____

_____

Other medications you took in the last year not on current list:

_____

_____

* ***Medications you are allergic to***:

_____

_____

_____

SIGNATURE ON FILE

Allergy & Clinical Immunology
Joseph Pflanzer, M.D.

1. I understand that I am financially responsible for all co-payments, deductibles, co-insurance or non-covered services.
2. I hereby authorize release of patient information to my insurance company(ies) and authorize my doctor to act as my agent in helping me obtain payment.
3. I will respond within **15 days** to any request for additional information or change made by my insurance company(ies) and accept full responsibility for payment of services if the information is not provided.
4. I authorize all medical payments, for services received in your office, sent directly to Joseph Pflanzer, M.D.
5. I understand that I must take role upon helping your office receive any referral from my Primary Care Physician.
6. I understand, all services received without proper authorization or referral from my PCP will be my responsibility.
7. ***Failure to keep my appointment without a minimum of 24 hour notice may subject to a $25 – $50 fee to my account.***
8. I understand that this authorization is valid up to 1 yr of the signed date, unless otherwise stated by me in writing.

Patient Name: _____ D.O.B: _____

Responsible Party: _____ Relationship:_____

Signature: _____ Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Birthdate:_____

Signature: _____ Date:_____