

Allergy & Asthma Physicians, S.C.

Name: _____ SS # _____

Address: _____ Email: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone: _____ Home
Mobile
Work Additional Phone: _____ Home
Mobile
Work

Birthdate: _____ Marital Status: _____ Student? no full time part time

Who is your Primary Care Doctor: _____

Address: _____ Phone: _____

Who referred you: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Who is responsible for payment*? Address, if different: _____

*(If patient is a minor)

❖ **PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST.** ❖

Insurance Company: _____ Do you want us to bill your insurance? yes no

Please circle: PPO Medicare HMO Other if HMO: Amita Loyola (MacNeal) if Other: _____

Group #: _____ Subscriber ID #: _____

Primary Subscriber: _____ Relationship to insured: Self
Spouse
Child

❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖

I authorize the release of any medical information necessary to process my insurance claim to my insurance company. I authorize the payment of medical benefits to Allergy & Asthma Physicians, unless otherwise noted. I understand that Allergy & Asthma Physicians will bill my *primary* insurance as a courtesy to me. Any balance that remains unpaid after 45 days will be my responsibility.

Signature: **X** _____ Date: _____

I acknowledge receipt of Allergy & Asthma Physicians Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that Allergy & Asthma Physicians has reserved a right to change the privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signature: **X** _____ Date: _____

Relationship, if not patient: _____

Allergy & Asthma Physicians, S.C.

Credit Card Authorization Form

Allergy & Asthma Physicians has implemented a new credit card policy requiring all patients to keep a credit or debit card securely on file. This policy helps simplify billing, reduce administrative costs, and ensure timely payment for services.

Policy Overview:

- Patients will be asked to provide a credit or debit card to be kept securely on file at their first visit.
- Card information is stored in a secure PCI-compliant system.
- After your insurance is processed, you will receive an explanation of benefits (EOB) from the insurer. Allergy & Asthma Physicians will send you a billing statement of any patient responsibility before charging your card. These charges will not exceed the amount shown as “patient responsibility” by your insurance company.
- Your card on file may be used for the following purposes:
 - Patient balances after insurance has paid (deductible, non-covered services or co-insurance)
 - Copays not collected at time of service
 - Telehealth fees
 - Outstanding balances older than 45 days of billing notification (unless prior payment plan has been established)
- If you believe a charge is incorrect, please contact our office within 15 days of the notice and any necessary adjustments can be made.
- It is **your responsibility** to ensure that the credit card information on file remains current.

By signing below, I authorize Allergy & Asthma Physicians to charge my credit card for any outstanding balances when due unless other payments arrangements have been previously established.

[] Please check this box if you prefer not to receive a statement and would like us to bill your credit card immediately for any balances due after the processing of your insurance.

Credit Card Holder's Signature: _____ Date: _____

Visa ☐ Mastercard ☐ Amex ☐ Discover ☐

Patient's Name (Print): _____

Name on Card (Print): _____

Credit Card Number: _____

Exp Date: _____ Security Code: _____

Email Address: _____

PATIENT NAME: _____ DATE: _____ D.O.B. _____

Please answer **all** questions on the following **three** pages to the best of your ability.

1.) Briefly describe the problem(s) which have caused you to see the doctor today. _____

2.) Has your child ever been hospitalized or seen in the emergency room for this/these problem(s)? Yes____ No____
(If yes, state when.) _____

3.) Which time of day are your child's symptoms worse? (circle) Morning Afternoon Evening Nighttime

4.) Do the symptoms ever awaken your child at night? Yes____ No____ If yes, how often? _____

5.) Are the symptoms worse during certain seasons? Yes____ No____

If yes, which season? (circle) Winter Spring Summer Fall

7.) Are your child's symptoms triggered or worsened by exposure to any of the following **allergens**? (circle)

Dust Pollens Cats Dogs Mold (raking leaves, hay rides, damp basements) Other _____

8.) Are your child's symptoms triggered or worsened by exposure to any of the following **irritants**? (circle)

Smoke Perfumes Strong Odors Cold Air Exercise Other _____

9.) Please list other factors which you feel are associated with triggering your child's symptoms. _____

10.) Please list the names of **all** medications your child is currently taking, including over the counter _____

11.) Please list any drug allergies: _____

Other physicians your child has seen for this/ these problems: _____

PAST HISTORY

Birth History

Born where? _____ Birth Weight : _____

Length of Pregnancy _____ Any complications with delivery? _____

Feeding History

Breast (how long?) _____ Formula _____ Any troubles with feeding (vomiting, gas, diarrhea, etc.)? _____

Immunizations

(Up to Date?) _____

Any adverse reactions ? _____

Illnesses

Has your child ever been **diagnosed** with any of the following? (Please check **YES** or **NO**)

	YES	NO	<u>Physician Comments</u>
Asthma	_____	_____	
Hay fever/ Allergic Rhinitis	_____	_____	
Sinus Problems	_____	_____	
Ear infections/ fluid in ears	_____	_____	
Eczema/ Dermatitis	_____	_____	
Bronchitis	_____	_____	
Bronchiolitis	_____	_____	
Pneumonia	_____	_____	
Chicken Pox	_____	_____	
Measles	_____	_____	
Croup	_____	_____	
Arthritis/ Joint aches	_____	_____	

Other: _____

Any Surgeries? _____

Any Blood Transfusions? Yes No

Any Hospitalizations? _____

Reviewed By _____ M.D.

PATIENT NAME: _____ (Peds) DATE: _____ D.O.B. _____

ENVIRONMENTAL SURVEY

Please **check** or **complete** the answers to describe your home.

Type of Home: House _____ Apartment _____ Other _____

Approximate age of home: _____ years Years of occupancy _____

Location: City _____ Suburban _____ Country _____

Near your home is there a: Barn _____ Prairie _____ Factory _____ Other _____

Obvious mold/mildew? Yes / No Lots of dust? Yes / No Roaches? Yes / No

Heating System: Forced Air _____ Radiator _____ Baseboard _____ Other _____

Air Conditioning: Central _____ Window units _____ Fans _____ How often do you change the air filter? _____

In the spring / summer / fall windows are primarily kept: Open _____
Closed _____

Floor coverings: Carpet _____ Area rug _____ Wood _____ Other _____

Is there a basement or crawl space? Yes _____ No _____ Is the basement damp or musty? Yes _____
If yes, do you spend much time in the basement? _____ Yes _____ No _____

BEDROOM

Located in: Basement _____ First Floor _____ Second Floor _____ Attic _____

Floor Covering: Carpet _____ Area rug _____ Wood _____ Other _____

Bed mattress: Conventional _____ Futon _____ Water _____

Pillows: Synthetic/Foam _____ Feather/Down _____

Comforter: Cotton/Synthetic _____ Feather/Down _____ Wool _____

Household Pets: Cat _____ Dog _____ Bird _____ Other _____

Do they go into the bedroom? Yes _____ No _____

SMOKERS IN FAMILY No Yes (who?)

Did Parent or Caretaker previously smoke around the child (at home, in car, in restaurants)? No Yes (Who)?

PARENT's OCCUPATION: Mother _____ Father _____

SCHOOL HISTORY:

Does or did your child attend daycare or pre-school ? _____

How many days of school (day care) per year has your child missed due to illness ? _____

Does your child have symptoms during gym class or other activity ? _____

Does your child take any medications at school (day care) ? _____

Is your child exposed to any of the following at school (day care) ? **(circle)**

Animals (rabbits, mice, etc.) Dusts Chemicals Smoking Other _____

Reviewed By _____ M.D.

PATIENT NAME: _____ DATE: _____ D.O.B. _____

Family History: Please check all that apply to members of your family.

	Mother	Father	Siblings	Other Relative	Physician Comment
Allergic Rhinitis(Hay Fever)	_____	_____	_____	_____	
Asthma	_____	_____	_____	_____	
Sinus Problems	_____	_____	_____	_____	
Nasal Polyps	_____	_____	_____	_____	
Hives/ Swelling	_____	_____	_____	_____	
Eczema/ Dermatitis	_____	_____	_____	_____	
Drug Allergy	_____	_____	_____	_____	
Food Allergy	_____	_____	_____	_____	
Stinging Insect Allergy	_____	_____	_____	_____	
Emphysema/ COPD	_____	_____	_____	_____	
Chronic Bronchitis	_____	_____	_____	_____	
High Blood Pressure	_____	_____	_____	_____	
Heart Disease	_____	_____	_____	_____	
Diabetes	_____	_____	_____	_____	
Thyroid disorder	_____	_____	_____	_____	
Cancer	_____	_____	_____	_____	
Other _____	_____	_____	_____	_____	

Review of Systems:

 Please **circle** any of the following symptoms which your child is currently experiencing or which caused serious problems in the past.

General: fever, night sweats, weight changes, fatigue, loss of appetite

Eyes: itching, tearing, dry eyes, redness, swelling, discharge

Ears: ear fullness, popping, itching, loss of hearing, infections

Nose: sneezing, itching, runny nose, stuffy/congested, yellow/green discharge

Throat: sore throat, post nasal drip, itchy palate

Lymph glands: glandular swelling, glandular tenderness

Chest: cough, nighttime cough, wheezing, frequent respiratory infections, shortness of breath

Intestinal Tract: nausea, vomiting, indigestion, trouble swallowing, stomach pain, constipation, diarrhea, excessive gas

Urinary: trouble with urination, frequent urination, burning, urinary infections,

Rheumatologic: joint stiffness, joint swelling, joint pain,

Skin: rash, hives, welts, itching, eczema, hair loss

Neurologic: black outs, severe headaches, epilepsy(seizures), inability to concentrate, trouble sleeping

Other: _____ All Others Neg. _____

Reviewed By _____ M.D.