# FORT WORTH ALLERGY AND ASTHMA ASSOCIATES

**PATIENT DATA BASE** **Name:** ______________________ **Age:** _____ **Appointment Date:** ________

### *I. CHIEF COMPLAINT:*

### *II. PRESENT HISTORY:*

A. How long have you had the worst symptom?

B. Which seasons seem to affect you the most?
SPRING SUMMER FALL WINTER

C. What motivated you to seek consultation at this time?

### *III. SYMPTOMS*

| Nasal/Throat Symptoms | Never | Occasional | Frequent | All the Time |
|---|---|---|---|---|
| Nasal Congestion | 0 | 1 | 2 | 3 |
| Watery Discharge | 0 | 1 | 2 | 3 |
| Thick Drainage | 0 | 1 | 2 | 3 |
| Post nasal drainage | 0 | 1 | 2 | 3 |
| Sneezing | 0 | 1 | 2 | 3 |
| Itching nose | 0 | 1 | 2 | 3 |
| Sore throat | 0 | 1 | 2 | 3 |
| **Eye Symptoms** | | | | |
| Watering | 0 | 1 | 2 | 3 |
| Itching | 0 | 1 | 2 | 3 |
| Tearing | 0 | 1 | 2 | 3 |
| Redness | 0 | 1 | 2 | 3 |
| **Chest Symptoms** | | | | |
| Shortness of breath | 0 | 1 | 2 | 3 |
| Wheezing | 0 | 1 | 2 | 3 |
| Chest tightness | 0 | 1 | 2 | 3 |
| Cough | 0 | 1 | 2 | 3 |

Worse at night?
Worse at exercise?
Phlegm Clear Colored

If applicable, how many:
Emergency room visits for asthma? __________
Hospitalizations for asthma? __________
ICU __________
Ventilator __________
Pneumonia? __________

Awakened from sleep because of asthma: Nights/month __________

Number of missed school or workdays in the past 12 months due to:
asthma __________
nasal symptoms __________
sinus infections __________

# of days/month that asthma interferes with work, school, or home activities: __________

| Skin Symptoms | Never | Occasional | Frequent | All the Time |
|---|---|---|---|---|
| Itching | 0 | 1 | 2 | 3 |
| Hives | 0 | 1 | 2 | 3 |
| Dry skin | 0 | 1 | 2 | 3 |
| Swelling | 0 | 1 | 2 | 3 |
| Eczema | 0 | 1 | 2 | 3 |

### *IV. MEDICATIONS*

What are your current medications?

| Name: | Helped? |
|---|---|
| | |
| | |
| | |
| | |
| | |

Rescue inhaler use in past month: # of days__________

Other medications you've used for any of your allergy symptoms in the past, including over the counter nasal drops and eye drops such as Visine or Naphcon A, and/or herbal therapies.

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |

### *V. AGGRAVATING FACTORS:*

| | Nose | Chest | Eyes | Skin |
|---|---|---|---|---|
| Exercise | | | | |
| Cold air | | | | |
| Infections | | | | |
| Weather changes | | | | |
| Cigarette smoke | | | | |
| Laughing | | | | |
| Emotional stress | | | | |
| Grass mowing | | | | |
| Dust exposure | | | | |
| Foods | | | | |
| Animals | | | | |
| (Which animals) | | | | |
| Mold (mildew) | | | | |
| Menstruation | | | | |
| Pregnancy | | | | |
| Other | | | | |

### *VI. INSECT STINGS*

Have you ever had a severe reaction to an insect bite or sting?
Which insect?
Describe the reaction:

## VII. HEADACHE HISTORY:
(answer only if headaches are a major problem)

How long have you had them?
Where does it hurt?
Can you predict when they are coming?
Do they make you nauseated?
Do they make you vomit?
Can you think of anything that brings them on?

Any warning symptoms (flashing lights, dots...)?

What does it take to get over one?
Have you seen a neurologist?
Name the medications used to treat this in the past:

## VIII. MEDICAL HISTORY:

Please list all other medically diagnosed conditions:

List any previous surgeries:

## IX. PAST ALLERGY WORKUP/TREATMENT:

Have you been treated for allergy before?
Was skin testing done? When?
Which doctor?
Results:

Was blood testing (for allergies) done?
Results:

Have you been on allergy immunizations?
Where was this done? (Home/office)
How long were you immunized?
What results did you get? (None, some, cured)
Would you consider it again?

## X. DRUG ALLERGIES:

| Drug | Reaction | Date |
| --- | --- | --- |

Does anyone in your immediate family (mother, fat- grandparent, sister, brother) have any of the following:

Which member

Hay fever __________
Sinus problems __________ Nasal polyps ______
Asthma __________
Emphysema __________
Bronchitis __________
Eczema __________
Migraine __________

## XI. ENVIRONMENTAL HISTORY:

Home: year built ______ Type ______
Urban ______ Suburban ______ Rural ______

Are there mold (mildew) problems?

Who smokes, where, and how long in your household? (including yourself)

What pets do you have, and where are they kept?

Are pets allowed in the patient's bedroom?

What type of mattress does the patient sleep on?

Boxspring ______ Waterbed ______
Pillow:
Synthetic ______ Feather ______ Foam ______

Is the bedroom carpeted?
Is there heat and air conditioning?
Central ______ Other ______
HEPA filters ______ Wood burning stove ______
Electrostatic filters ______

Day care ______
School grade ______
Sports ______

Are there school or work allergy triggers?
If so, what?

Occupation ______ Location ______

## XII. WHO IS YOUR PERSONAL PHYSICIAN?

## XIII. WHO REFERRED YOU TO US?

Please use this space to expand on any portions of your history not covered in the above questions

# Financial Policy

**Payment for all services is due at the time that services are provided.** Payment may be made by cash, personal check, or credit card- we accept Visa, MasterCard and Discover.

**Health insurance co-pays, co-insurance fees and deductible fees must be paid at the time that services are provided.** As a courtesy to you, we will verify your medical benefits with your health insurance provider and attempt to determine what amount must be paid based on the information available at the time of your visit. However, up-to-date information is not always available, and adjustments may be necessary based on the response from your health insurance provider.

The insurance contract is between you, the patient, and your health insurance company, and it is your responsibility to be aware of what your health insurance coverage entails. The amount paid by your insurance company may not fully cover the amount charged for the services provided, and ultimately the obligation for payment of services rests with you, the patient. We will provide whatever information is necessary to assist in obtaining proper insurance reimbursement.

For patients who do not have health insurance, please inquire about our discounted rates.

## ELECTRONIC BILLING NOTIFICATION

**As part of our commitment to efficiency and security, Fort Worth Allergy & Asthma Associates utilizes a secure electronic billing system.**

**Standard Delivery**: **Our primary billing method is via secure email notification**. You will receive an email advising you that a new statement is available for review and payment through our secure patient portal.

**Patient Responsibility:** By providing your email address, you acknowledge that billing notices will be sent to that address. **It is your responsibility to maintain an accurate email address on file with our office and to monitor that email for outstanding balances**.

**Paper Statements:** If you require paper statements to be mailed via USPS, please notify the front desk.

## FEE FOR MISSED APPOINTMENTS

There will be a **$25 charge** for missing a scheduled appointment without notifying our office within one working day of the appointment time.

***I have read the financial policy above, and I agree to the terms stated therein by Fort Worth Allergy & Asthma Associates. I accept full responsibility for my account and recognize that I will be responsible for any balances unpaid by my health insurance plan provider.***

Signed: ______________________________ Date: ________________

Allergy, Asthma and Clinical Immunology

**Fort Worth Allergy & Asthma Associates**

4200 S. Hulen Suite #230
Fort Worth, TX 76109

Office: (817) 315-2550
Fax: (817) 900-0589

**Andrew Beaty, M.D., P.A.**

**Millard Tierce IV D.O.,P.A.**

# New Patient Information

Welcome to Fort Worth Allergy & Asthma Associates!

Your appointment is with Dr.__________________ on __________________ at ____________.

If you are paying for this visit without insurance, your visit cost may range from $165-$800, depending on the need for and extent of allergy testing that may be done during your visit. You will be able to discuss your testing options with your doctor at the time of your visit. Payment is expected at the time of your appointment. If you need to arrange a payment plan, please contact us prior to your visit to do so.

Your health insurance coverage is a contract between you and your insurance company. If your insurance plan requires you to have a referral, it is **your responsibility** to obtain the referral **prior to your appointment**. If a referral is required, please contact your primary care physician's office as soon as possible, as it may take up to a week to process the referral. If you come for an office visit without a current referral, you will be asked to reschedule your appointment or to pay out of pocket for your visit.

You will need to bring your insurance card at the time of your visit. If your insurance plan has a co-pay, you will need to be aware of that amount. For some insurance plans, office visit co-pays are higher for specialist visits (**we are specialists**) than for primary care visits. We will collect your co-pay at the time of service. If you have not met the deductible for your insurance or co-insurance fees apply, we will collect payment for the services provided. Please read the attached financial policy carefully, and feel free to ask our staff if there are any questions.

**PLEASE DO NOT MAIL THESE FORMS BACK TO THE OFFICE. YOU SHOULD COMPLETE THE FORMS AT HOME AND BRING THEM TO US AT THE TIME OF YOUR APPOINTMENT.**

**IF YOUR FORMS ARE NOT COMPLETED AT THE TIME OF YOUR APPOINTMENT, IT MAY BE NECESSARY FOR YOU TO RESCHEDULE. PLEASE ARRIVE EARLY TO COMPLETE YOUR PAPERWORK IF YOU HAVE NOT DONE SO PRIOR TO ARRIVAL.**

Please do not hesitate to call us at (817) 315-2550 if you have any questions. We look forward to meeting you.

**Patient name (printed):** ____________________________ **Date:** ____________________

**Signature (Patient/Parent/Guardian):**____________________________________________

Allergy, Asthma & Clinical Immunology

**FORT WORTH ALLERGY AND ASTHMA ASSOCIATES**

www.fwallergy.com

4200 S. Hulen Suite #230 ◆ Fort Worth, Texas 76109-4924 ◆P 817-315-2550 ◆ 817-900-0589

Andrew D. Beaty, M.D., PA   Robert J. Rogers, M.D., PA   Millard L. Tierce, D.O., PA

## ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

**PATIENT'S NAME: (last)**________________________**(first)**____________________**(MI)**______

Notice of privacy practices: I acknowledge that I have reviewed the practice's Notice of Privacy Practices, which describes the ways in which FWAAA may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact FWAAA directly if I have a question or a complaint.

________________________ ______________________________ ________________

**Print Name** **Signature of patient/parent/guardian** **Date**

**Communication/messages**: When FWAAA needs to leave messages when we are unable to reach you, please list how you would like to be contacted and what information we can share.

| | | |
|---|---|---|
| Cell Phone #:____________________ | Leave message with confirmation of appointment only | Y N |
| | Leave call back number only | Y N |
| | Leave message with detailed information | Y N |
| Home Phone #:____________________ | Leave message with confirmation of appointment only | Y N |
| | Leave call back number only | Y N |
| | Leave message with detailed information | Y N |
| Work phone #: ____________________ | Leave message with confirmation of appointment only | Y N |
| | Leave call back number only | Y N |
| | Leave message with detailed information | Y N |

**I wish to opt out of the automatic appointment reminder system: Y N**

**Family members/parents/friends: I authorize FWAAA to share my Health Information with the following:**

Name:____________________________________Relationship:____________________

Name:____________________________________Relationship:____________________

Name:____________________________________Relationship:____________________

*I may revoke my consent in writing by completing a new Acknowledgement of Privacy Notice and Designation of Disclosure form except to the extent that the practice has already made disclosure in reliance upon my prior consent.*

______________________________ ______________________________ __________

**Print Name** **Signature of patient/parent/guardian** **Date**

**FORT WORTH ALLERGY & ASTHMA ASSOCIATES**
**4200 S. Hulen St. Suite #230**
**Fort Worth, TX 76109**
**(817) 315-2550 Fax (817) 900-0589**

Appointment Date: ________________

Doctor: __________________________

**Patient Name (Last)** ________________________ **(First)** ______________________ **(MI)** _________

**Address** ____________________________________ **City** _______________ **State** ____ **Zip** _______

**Cell Phone** ___________________ **Home Phone** ___________________ **Work Phone** ____________

**Social Security #** ________________________ **Occupation** __________________________________

**Date of Birth** ______/_______/_______ **Sex** ________ **Marital Status** _________________________

**Email Address** _________________________________________________________________________

***************<u>**Email address is required for electronic billing notifications**</u>******************

**Referring Physician & Phone Number** _____________________________________________________

<u>**Insurance Information**</u>**: (This section must be completed if you want us to file your insurance; do not fill out if you have an indemnity plan or an insurance plan with which we are not contracted)**

**Insurance Company** ____________________________________________ **Referral Required? Yes/No**

**Employee who carries Insurance** ___________________________ **Date of Birth** _____/_____/_____

**Member ID #** ____________________________________ **Group #** ___________________________

**Social Security # of Insured** __________________ **Employer** _________________________________

**Relationship to Patient:** ________________________________________________________________

**Parent/Guarantor (if patient is a minor)**__________________________________________________

**Address (if different from patient)** ______________________________________________________

**City** ______________________________________ **State** ___________ **Zip Code** _________________

**Cell Phone** _________________________________ **Home Phone** _______________________________

**Emergency Contact Name** _____________________________ **Relationship to Patient** ____________

**Cell Phone** _________________________________ **Home Phone** ______________________________

**Payment for Service**: I understand I am responsible for payment of all fees for services rendered by Fort Worth Allergy & Asthma Associates. If applicable, I authorize direct payment of medical benefits to Fort Worth Allergy & Asthma Associates. If insurance denies a claim for any reason, or if co-pays, deductibles, or co-insurance apply, I agree to pay any outstanding balance due beyond insurance.

**Signature (or guarantor, if minor)** ___________________________________ **Date**___________

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## MEDICATIONS TO AVOID PRIOR TO ALLERGY SKIN TESTING

Antihistamine medications can interfere with allergy skin test results. We recommend stopping any antihistamine medication **at least 5-7 days prior** to an allergy skin test appointment. **Any OTC medication that says "Allergy" or "PM" should be assumed to contain antihistamine medication.**

*If you have any questions about specific medications prior to testing please call us at (817)315-2550 to reach the nurse for Dr. Beaty (ext 207) or Dr. Tierce (ext 211).*

**Common Oral Antihistamines:**

Cetirizine (Zyrtec)
Levocetirizine (Xyzal)
Fexofenadine (Allegra)
Loratadine (Claritin, Alavert)
Desloratadine (Clarinex)
Diphenhydramine (Benadryl)
Chlorpheneramine (Chlor-Trimeton)
Hydroxyzine (Atarax, Vistaril)
Brompheneramine (Brom-phed, Dimetapp)
Cyproheptadine (Periactin)
Clemastine (Tavist)
Promethazine (Phenergan)
Doxylamine (NyQuil, Unisom)

**Antihistamine Nasal Sprays:**

Azelastine (Astelin, Astepro)
Olopatadine (Patanase)
Dymista (contains azelastine)
Ryaltris (contains olopatadine)

**Antihistamine Eye Drops:**

Olopatadine (Pataday, Patanol)
Ketotifen (Zatidor, Alaway)
Azelastine (Optivar)
Bepotastine (Bepreve)
Epinastine (Elestat)

**GERD/Antacid Medications:**

Famotidine (Pepcid)
Cimetidine (Tagamet)
Ranitidine (Zantac)
Nizatadine (Axid)

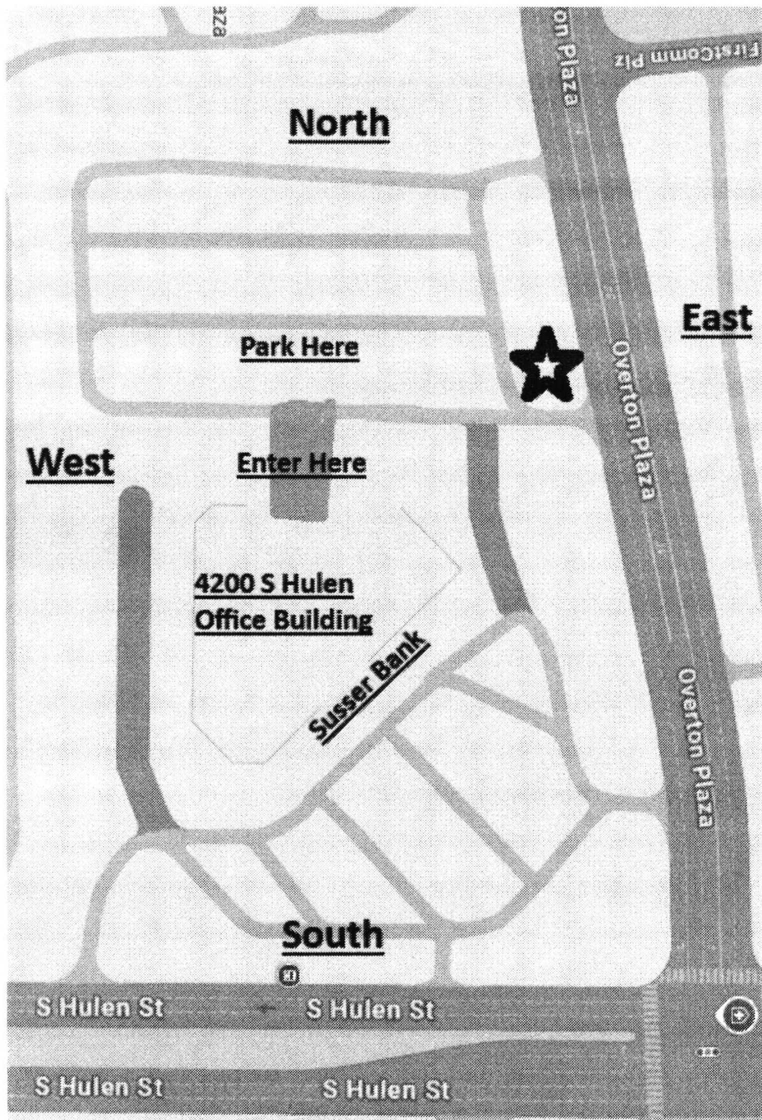
**Combination OTC Products:**

Cold/Sinus medications
Allergy/Congestion products
Nighttime pain relievers
Sleep aids

## OK to continue these medications:

Asthma inhalers (both rescue and controller inhalers)
Nasal steroid sprays (Nasacort, Flonase/fluticasone, Nasonex, Rhinocort)
Montelukast (Singulair)

*****Many anti-depressant and mood stabilizer medications have potential antihistamine properties, but we do not generally stop these medications for testing. Please let the nurse or physician know prior to testing if you are taking one of these medications.**




## 4200 S. Hulen Office Building

**Driving Directions:**

Turn on to Overton Plaza off S Hulen. Go past the 1st Drive way on the left and enter the 2nd drive way on the left (where the star is) on the west side of the building to enter the building. We are in suite 230.