FORT WORTH ALLERGY AND ASTHMA ASSOCIATES

PATIENT DATA BASE **Name:**_____ **Age:**____ **Appointment Date:**_____

I. CHIEF COMPLAINT:

A. The most troublesome symptoms you have are:

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

	Never	Occasional	Frequent	All the Time
Nasal/Throat Symptoms				
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, father, 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: _____

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** _____

Email Address _____

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

Social Security # _____ **Occupation** _____

Date of Birth _____/_____/_____ **Sex** _____ **Marital Status** _____

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** _____

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**

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):_____

FORT WORTH
Allergy and Asthma Associates

Fort Worth Allergy & Asthma Associates

MEDICATIONS THAT MAY INTERFERE WITH SKIN TESTING

These medications must be avoided for at least 3 days prior to skin testing, unless otherwise specified **

Some medications must be avoided *at least 5 DAYS* and are marked with an (*)

If you are taking a medication on this list for a chronic condition, such as depression, do not stop that medication without first checking with us or the prescribing physician to make sure it is safe to do so. Call (817) 315-2550 to reach Dr. Bailey (ext. 205), Dr. Beaty (ext. 207) or Dr. Rogers (ext. 209).

****Do Not Stop Asthma medications or Steroid nasal sprays such as Flonase or Nasacort prior to testing.**

Do Not Take any OTC medications with the word "Allergy" on the packaging for 3-5 days prior.

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A

Acetaminophen PM
Accu-Hist LA
Advil PM
***Alavert**
Alka-Seltzer Plus
***Allegra, Allegra-D**
Aller-Rx PM
Allergy Eye Drops
Alprazolam
Amitryptiline
Anafranil
Antivert
Astelin nasal spray
Astepro nasal spray
Atarax
Azelastine nasal spray
Azelastine eye drops

B

Benadryl
Bepreve eye drops
Bromfed, Bromfed PD
Brompheneramine
Brovex D

C

Caladryl lotion
Carbonoxamine
***Cetrizine**
Chlorpheneramine
Chlrotrimeton
Cimetidine
Citalopram
***Claritin, Claritin-D**
***Clarinex**
Clomipramine
Cyproheptadine

D

Desipiramine
***Desloratadine**
Dimetapp
Diphenhydramine
***Doxepin**
Doxylamine
Dramamine
Dymista nasal spray

E

Elavil
Elestat eye drops
Emadine eye drops
Excedrin PM

F

Famotidine
***Fexofenadine**
Fluoxetine

H

Hydroxyzine

I

Ibuprofen PM
Imipramine

K

Ketotifen eye drops

L

Lastacaft eye drops
Lexapro
***Levocetirizine**
***Loratadine**

M

Meclizine
Midol
Montelukast (stop 1 day prior)

N

Nefazadone
Norpramin
Nortryptiline
Nyquil

O

Olopatadine eye drops
Olopatadine nasal spray
Optivar eye drops

P

Palgic
Pamelor
Paroxetine
Pataday eye drops
Patanase nasal spray
Patanol eye drops
Paxil
Pazeo eye drops
Pediacare night rest
Pepcid
Periactin
Phenergan
Phenhydramine
"PM"- containing medications
Promethazine
Protryptiline
Prozac

R

Ranitidine

V

Vistaril
Vivactyl

X

Xanax
*Xyzal

Herbs

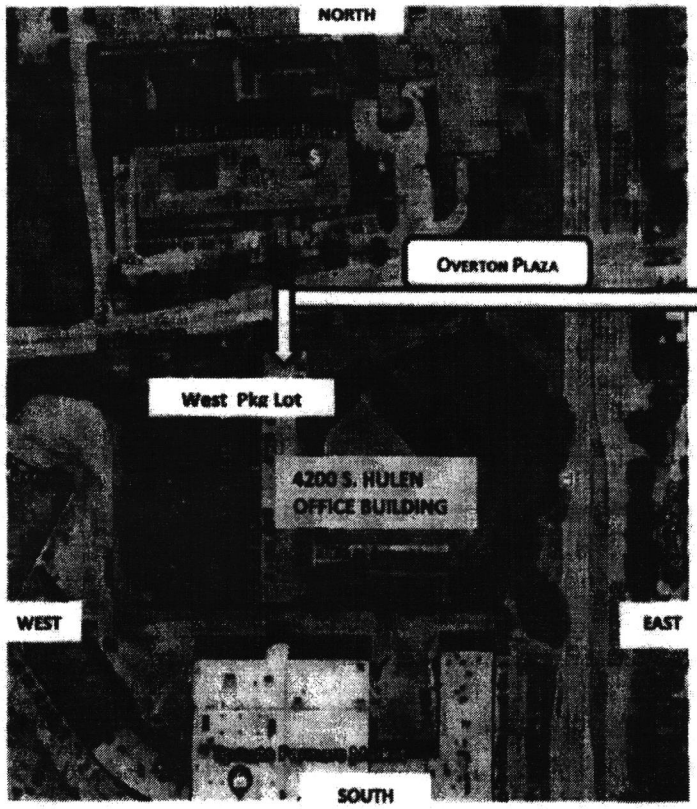
Licorice
Green Tea
Saw Palmetto
St. John's Wort
Feverfew

Z

Zaditor eye drops
Zantac
Zoloft
Zonalon cream
*Zyrtec, Zyrtec-D

If you have any questions about stopping your medicines prior to your visit, please contact us at 817-315-2550.

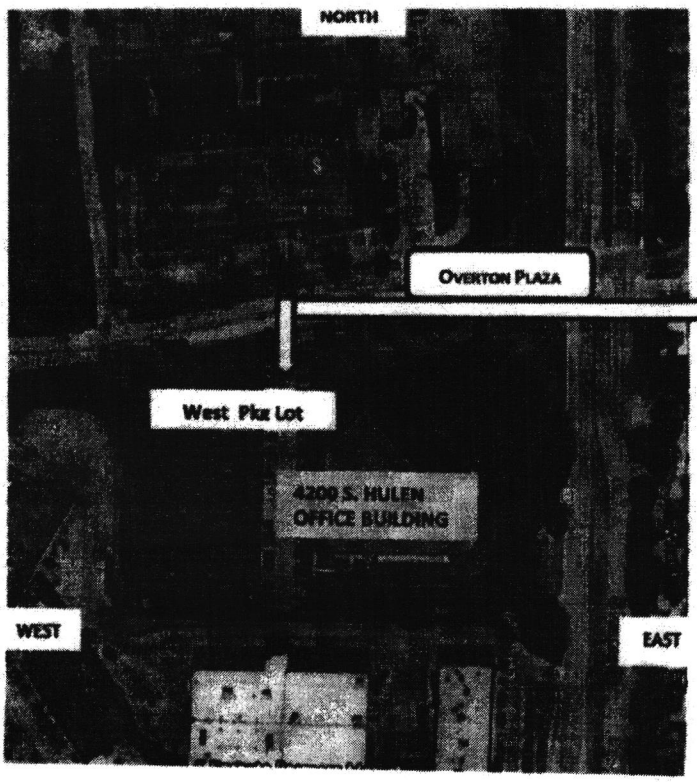
***AVOID AT LEAST 5 DAYS PRIOR TO TESTING**



4200 S. HULEN OFFICE BUILDING

DRIVING DIRECTIONS:

TURN ON TO OVERTON PLAZA OFF S. HULEN. GO PAST OUR 1ST PARKING LOT (ON THE LEFT) AND ENTER THE 2ND PARKING LOT LOCATED ON THE WEST SIDE OF OUR BUILDING TO ENTER THE BUILDING.



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