

Personal Information Sheet

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary Care Physician (First Last): \_\_\_\_\_ City: \_\_\_\_\_

Pharmacy (Name and Location-Cross Streets): \_\_\_\_\_

Briefly describe the reason for your visit today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How did you hear about our practice?  Physician: \_\_\_\_\_  Friend: \_\_\_\_\_

Insurance Co.  Ad  Internet: \_\_\_\_\_  Other: \_\_\_\_\_

Current Medical Problems- Please list all current medical problems: **(Do not include resolved problems from your past)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medication- Please list all current **OTC** and **prescription medicines**, herbal remedies: **(include DOSE & DIRECTIONS)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Social History- Please answer the following questions regarding your social/occupational status:

1. Do you currently smoke? YES  NO  If yes, how long? \_\_\_\_\_

2. Do you live with someone that smokes? YES  NO  If yes, how long? \_\_\_\_\_

3. Do you have a history of smoking in the past? YES  NO  If yes, how long? \_\_\_\_\_

4. Are you routinely exposed to pets? YES  NO  If yes, please list: \_\_\_\_\_

\_\_\_\_\_

5. Are you exposed to mold? YES  NO  If yes, where? \_\_\_\_\_

6. Are you exposed to fumes/strong odors? YES  NO  If yes, where/what? \_\_\_\_\_

7. Are you exposed to chemicals? YES  NO  If yes, where/what? \_\_\_\_\_

8. Please note your current occupation (If Applicable): \_\_\_\_\_

9. Are you routinely exposed to birds/pigeons/dove/fowl? YES  NO  If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Past Medical History- Please list all past resolved medical problems **(Do not include active/current problems)**:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergy History- Are you allergic to any **food, drug/medicine, chemical, latex** or **insects**? YES  NO

If yes, please list: \_\_\_\_\_

Birth History- Please answer the following questions regarding the patient's birth:

1. Was your birth?  On Time or  Premature^~~was~~ premature, how many weeks? \_\_\_\_\_

2. Please list any other complications you experienced during delivery or after birth: \_\_\_\_\_

\_\_\_\_\_

Past Surgical History- Please list U past surgeries, **H Y X U H Y** that they were performed, and the **gi fl Ycbfu' bUa Y**:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





**Southwest Allergy & Asthma Center**

*John Van Wagoner, MD, PA*

**CONSENT FOR USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION**

**And**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**Purpose of Consent:** By signing this form, you consent to our use and disclosure of your protected health Information (PHI) to carry out treatment, payment activities, and healthcare operations (TPO).

**Notice of Privacy Practices:** Our office promises not to disclose your PHI (name, address, phone number(s), social security number, date of birth, etc.) outside of the TPO without your specific authorization and consent. Our office complies with HIPAA and all federal and state laws regarding the privacy of your information. A copy of our Notice of Privacy Practices document is posted on our website in the helpful links section and a copy is available to you at any time at our office.

You may refuse to sign this authorization.

Acknowledged and agreed to by:

PATIENT or PARENT SIGNATURE \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

**OPTIONAL: Disclosure of Protected Health Information**

I understand that any and all medical care that I receive at Southwest Allergy and Asthma Center will be treated with the utmost confidentiality. To facilitate my medical care, I hereby authorize Southwest Allergy and Asthma Center to disclose PHI about my treatment and medical condition to the following individuals:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_



**PLANO**  
6101 Windcom Court  
Suite 400  
Plano, TX 75093  
Ph: (972) 398-3500  
Fax: (972) 398-3512

**DENTON**  
3105 Colorado Blvd.  
Suite 101  
Denton, TX 76210  
Ph: (940) 387-1700  
Fax: (940) 387-1722

**DENISON**  
5012 South US HWY 75  
Suite 150  
Denison, TX 75020  
Ph: (903) 463-8400  
Fax: (903) 463-8500

## **PATIENT FINANCIAL ADVISORY**

### **NON-COVERED SERVICES**

\_\_\_\_\_(initials) I understand Southwest Allergy and Asthma Center (SWAAC)'s contractual agreement with health care service plans relates only to items and services which are deemed "covered" by the individual health plan. Consequently, I accept full financial responsibility and agree to pay out-of-pocket for all items or services which are deemed "non-covered" by the individual health plan.

### **HMO REFERRALS**

\_\_\_\_\_(initials) I understand that if my insurance company has designated a primary care physician (PCP), I am required to have prior authorization from my PCP prior to my office visit. If the authorization is not provided, whether by the Guarantor or through the insurance carrier, the Guarantor will be asked to either reschedule the appointment or pay for the visit out-of-pocket at the time of service.

### **SELF-PAY ACCOUNTS**

\_\_\_\_\_(initials) Self-pay accounts are those (1) with no available health insurance coverage at the time of service or (2) are covered by an insurance carrier with which SWAAC does not participate. I agree to be individually responsible to pay the full charges at the time of service if I have a self pay account.

### **CHANGES TO COVERAGE**

\_\_\_\_\_(initials) I understand that it is my responsibility to advise SWAAC of any changes with my insurance carrier, to confirm the practice's participation, and my eligibility prior to each visit. I agree to pay the full charges of all services rendered by SWAAC if services are deemed "non-covered."

### **SERVICES RENDERED**

\_\_\_\_\_(initials) I agree that in return for services provided to the patient by SWAAC, the account balance will be paid at the time service is rendered or I will make appropriate financial arrangements satisfactory to SWAAC for payment. If co-payments, deductibles or co-insurance amounts are designated by a contractual agreement to an insurance provider or health plan, I agree to pay these amounts to SWAAC. I understand and agree that if my account is delinquent, my account may be referred to a third-party agency for collections and fees may apply if such services are utilized. If extenuating circumstances should prevent me from providing payment, I may discuss the matter with a Treatment Coordinator.

- As a courtesy, SWAAC files claims to your insurance provider. If you are covered by insurance, it is your responsibility to understand the provisions under which you are covered.
- Missed or cancelled appointments with less than a 24 hour notice will be subject to a \$25 no-show fee.
- A minimum fee of \$25 may be assessed to release medical records.
- In the event that a guardian shares custody of a patient, the guardian present at the time of service is responsible for payment in full at that time. If you have a court order requiring treatment costs to be shared, it is the responsibility of the guardians to make appropriate arrangements prior to treatment.
- All returned checks will be assessed a \$25 fee.

**My signature below indicates I understand and agree to pay in full any balance unpaid by my insurance provider.**

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
\*Legal Representative's Printed Name

\_\_\_\_\_  
Legal Representative's Signature

\_\_\_\_\_  
Date

*If representative, specify relationship to patient*



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Patient Name: _____
Patient Address: _____ _____ _____
City, State, Zip
Date of Birth: _____ Sex: _____
Daytime Phone: _____ (Hm/Wk/Mb)
Allergist: _____

**Confidential Voicemail Authorization**

From time to time in caring for our patients, it may become necessary to contact you by telephone. In the event that you are not available to answer when we call, we would like to be able to leave detailed telephone messages regarding your care. If you would like us to provide this service, please complete the authorization below and list the telephone number(s) at which you would like to receive messages regarding your treatment.

I, \_\_\_\_\_, give Southwest Allergy and Asthma Center and their staff my permission to leave confidential messages regarding my treatment on the following voicemail machines:

- My home or cell phone** Telephone Number: \_\_\_\_\_
- My spouse's (name)** \_\_\_\_\_ Telephone Number: \_\_\_\_\_
- Other (name)** \_\_\_\_\_ Telephone Number: \_\_\_\_\_

\_\_\_\_\_  
 Patient's Printed Name

\_\_\_\_\_  
 Patient's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 \*Legal Representative's Printed Name

\_\_\_\_\_  
 Legal Representative's Signature

\_\_\_\_\_  
 Date

*\*If representative, specify relationship to patient*

\_\_\_\_\_  
 Witness

\_\_\_\_\_  
 Date