

Personal Information Sheet

Plano Denison

Location: Allen McKinney Patient Name: _____ Date: _____

Date of Birth: _____ Male Female

- 1. Primary Email: _____
- 2. Primary Phone Number: _____ Cell Home Work Spouse
- 3. Alternative Phone Number: _____ Cell Home Work Spouse
- 4. Primary Care Physician: First Name: _____ Last: _____ City: _____
- 5. Race: American Indian Asian Black Native Hawaiian White Type-Unknown
- 6. Ethnicity: Hispanic Origin Non-Hispanic Origin Type Unknown Language: _____
- 7. How did you hear about our practice? Physician- First and Last name: _____
 Friend(First and Last Name): _____ Internet Search: _____
 Insurance Company listing Print Ad: Other: _____
- 8. Briefly describe the reason for this visit: _____

9. **Current Medication-** Please list any and all **current OTC and Prescription medications** that you take regularly or as needed for any reason. Please indicate drug name, dose and dosing instruction: None

10. Please indicate the local pharmacy you would like for us to send your Rx if needed.
Please indicate pharmacy name, city, address and phone number:

11. Please indicate the mail-in pharmacy you would like for us to send your long term recurrent Rx if needed.
Please indicate pharmacy name, city, address and phone number:

12. Please indicate if you prefer liquid or tablet forms of medication if available. Liquid Tablet
13. **Past Medical History-** Please list any resolved problems that are no longer active: None

14. **Current Medical Problems-** Please list any active medical problems that have not resolved: None

15. **Past Surgical History-** Please list the type of surgery, date, and surgeons's first, last name: None

16. **Family History-** Please list any close relative(s) (mom, dad, brother, sister) that suffers from any asthma, allergies, skin conditions, autoimmune, and/or immune deficiency states: None Unknown

17. **Immunization History-**
A. Are your vaccinations up to date: Yes No Unknown If no, please explain why not: _____
B. Have you received a current flu vaccination? Yes No Unknown If yes, date: _____
C. Have you ever received the Pneumonia shot Pneumovax? Yes No Unknown If yes, date: _____
D. Have you ever received the Pneumonia shot Prevnar 13? Yes No Unknown If yes, date: _____
18. **Food Allergy-** Please list any **food** allergy/intolerance and the specific symptoms experienced: None

19. **Drug Allergy-** Please list any **drug** allergy/intolerance and the specific symptoms experienced: None

20. **Chemical Allergy-** Please list any **chemical** allergy/intolerance and the specific symptoms experienced: None

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21. **Insect Allergy-** Please list any **insect** allergy/intolerance and the specific symptoms experienced: None

22. **Social History-** Please answer the following questions regarding the patient's social status:

- A. Do you currently smoke? Yes No If yes, how long? _____ yrs
If yes, do you smoke daily? Yes No
- B. Do you live with someone that smokes? Yes No If yes, how long? _____ yrs
- C. Do you have a history of smoking in the past? Yes No If yes, how long? _____ yrs
- D. Are you routinely exposed to animals/pets? Yes No If yes, please specify the animal/pet: _____

E. Are you exposed to mold? Yes No Where? _____

F. Are you exposed to fumes/strong odors? Yes No Where/What? _____

G. Are you exposed to chemicals? Yes No Where/What? _____

H. Are you routinely exposed to birds/pigeons/dove/fowl? Yes No If yes, please list: _____

I. Please note the current occupation of the patient (If Applicable): _____

23. **Infection History-** Please answer the following questions regarding recent past infections: None

- A. Number of ear infections in the last 12 months: _____ Treated with antibiotics? Yes No
- B. Number of sinus infections in the last 12 months: _____ Treated with antibiotics? Yes No
- C. Number of episodes of sore throat in the last 12 months: _____ Treated with antibiotics? Yes No
- D. Number of episodes of Pneumonia in in your lifetime: _____ Treated with antibiotics? Yes No
- E. Number of episodes of Bronchitis in in your lifetime: _____ Treated with antibiotics? Yes No
- F. Other major infections in your lifetime and approximate date experienced/treated: None

24. Please list any oral or systemic steroids that you have received in the last year with the approximate date and condition for which the steroids were prescribed for: None

25. List of antibiotic names used in the last 12 months: None

26. **Review of Systems-** Please check any signs/symptoms/conditions that you **currently** experience: None

- Constitutional:** Fatigue Night Sweats Chills Fevers
- Respiratory:** Short of Breath Wheeze Cough Croup Tight Chest
- GI:** Heartburn Reflux Vomiting Diarrhea Trouble Swallowing
- Urinary:** Urinary Infection Blood in Urine Back Pain
- Frequent infections:** Sinusitis Pneumonia Ear/Throat Bronchitis Skin
- Musculoskeletal:** Stiff/Sore Joints Muscle Pain Red Swollen Joints
- Eyes:** Blurry Itch Water Red Frequent Infections
- Nose:** Runny Stuffy Itchy Sneeze Loss of Smell
- Chest:** Slow Heart Rate Palpitations Tight Chest Chest Pain Fast Heart Rate
- Neuro:** Numbness Seizures
- Skin:** Dry Itch Swelling Rash Hives
- Hematology:** Unusual Bleeding Unusual Bruising Swollen Lymph Nodes
- Endocrine:** Weight Gain Weight Loss Increased Thirst Cold Intolerance Heat Intolerance
- Psychology:** Anxious Depressed Stressed Worried

Other: _____

27. Any other information you would like to share about your upcoming visit:

My signature indicates that the above information is accurate to the best of my knowledge.

Patient/Guardian Name Patient/Guardian Signature Date completed/updated



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: This office will not 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. This office complies with HIPAA and all federal and state laws regarding the privacy of your information. The Notice of Privacy Practices is available on our website under Education. A printed copy is also available upon request.

You may refuse to sign this authorization.

Acknowledged and agreed to by:

_____	_____	_____
PATIENT/GUARDIAN SIGNATURE	PATIENT NAME	PATIENT DOB

DATE COMPLETED/UPDATED		

OPTIONAL: Disclosure of Protected Health Information

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

Name: _____ Relationship: _____

Date of Birth: _____ Phone Number: _____

Name: _____ Relationship: _____

Date of Birth: _____ Phone Number: _____

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. Excessive No-Shows will result in a non-refundable deposit prior to scheduling.
- 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



Confidential Voicemail Authorization

- Occasionally, it may become necessary to contact our patient(s) by telephone. In the event you are not available by phone, we will leave detailed voicemail messages regarding your/your child's treatment. By providing your telephone number(s), you hereby grant SWAAC permission to leave detailed voicemail messages regarding your/your child's treatment.

- My cell phone: _____
- My Home phone: _____
- Family Member _____
- Other (name): _____

Phone Number: _____ Phone Number: _____

- I do not wish to receive voicemail messages regarding my/my child's treatment.

Text/E-Mail Messaging Authorization

- To better serve you, we utilize text and/or email messaging for appointment reminders and important announcements. By providing your mobile number(s) and email address, you hereby grant SWAAC permission to contact you regarding appointment reminders and important announcements.

E-Mail: _____ **Cell:** _____

- I do not wish to receive text messages regarding appointments and important announcements.
- I do not wish to receive emails regarding appointments and important announcements.

Patient's Printed Name

Patient's Signature

Date

*Legal Representative's Printed Name

Legal Representative's Signature

Date

**If representative, specify relationship to patient*