# SWAAC Personal Information Sheet

## Personal Information Sheet

1. Patient Name: ____________________ Date of Birth: ____________

   Gender:
   ○ Female ○ Male

   Primary Phone: ____________________
   ○ Cell ○ Home
   ○ Work
   ○ Spouse

   Primary Email: ____________________

   Race:
   ○ American Indian ○ Asian
   ○ Black ○ Native Hawaiian
   ○ White ○ Type unkwown

   Street Address ____________________

   Home City ____________________

   Home State ____________________

   Home Zip Code ____________________

   Ethnicity:
   ○ Hispanic ○ Non-Hispanic ○ Type unknown

   Primary Language Spoken: ____________________

   Primary Care Physician First Name: ____________________

   Primary Care Physician Last Name: ____________________

   Primary Care Physician City: ____________________

   Patient Height: ____________

   Patient Weight: ____________

2. **If Patient is a minor please provide both parents full names below:**

   Father's First Name: ____________ Father's Last Name: ____________ Mother's First Name: ____________ Mother's Last Name: ____________

3. **How did you hear about our practice? Please be specific (i.e. first and last name).**

   ○ Physician
   ○ Internet search
   ○ Print ad
   ○ Friend
   ○ Insurance company listing
   ○ Other

4. **Please specify how you heard about us:**

   ____________________________________________

5. **Briefly describe the MAIN REASON(S) for this visit with our Allergy/Asthma/Immunology Specialist:**

   ____________________________________________

6. Briefly describe the specific OUTCOME you would like to obtain from this visit:

_______________________________________________

7. Do you currently use any Prescription or Over-the-counter medications for any condition?

☐ Yes ☐ No

8. Please list any and all current OTC and Prescription medications that you take regularly or as needed for any reason:

| | Medication | Dosage/Frequency | Reason for Use |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |

9. Please indicate the LOCAL pharmacy you would like for us to use if needed:

Pharmacy Name: ______ Pharmacy Phone: ______

Pharmacy Street Address: ______ Apt./Unit #: ______ City: ______ State: ______ Zip Code: ______

10. Please indicate the MAIL-IN pharmacy you would like for us to send your LONG TERM RECURRENT prescriptions if needed:

Pharmacy Name: ______ Pharmacy Phone: ______

Pharmacy Street Address: ______ Apt./Unit #: ______ City: ______ State: ______ Zip Code: ______

11. Please indicate if you prefer liquid or tablet forms of medication, if available:

○ Liquid
○ Tablet

12. Do you suffer from any ACTIVE/CHRONIC medical problems?

☐ Yes ☐ No

13. Please list any ACTIVE/CHRONIC problems that have NOT RESOLVED:

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

14. Have you suffered from any medical problem in the past that IS CURRENTLY RESOLVED?

☐ Yes ☐ No

15. Please list any resolved problems that are no longer active:

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

16. Have you had any surgical procedures?

☐ Yes ☐ No

17.

| | Surgery | Date | Surgeon First Name | Surgeon Last Name |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

18. Please list any close relative(s) (mom, dad, brother, sister) that suffers from any asthma, allergies, skin conditions, autoimmune, and/or immune deficiency states:

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

19. Immunization History: Are your vaccinations up to date?

○ Yes ○ No
○ Unknown

20. If no, please explain why not:

_______________________________________________

21. Have you received a flu vaccination for the current flu season?

○ Yes ○ No
○ Unknown

22. If yes, please specify date:

_______________________________________________

23. Have you received the Covid-19 Vaccine this year?

○ Yes
○ No

24. If yes, please specify date(s):

_______________________________________________

25. Have you ever received the pneumonia shot called Pneumovax?

- Yes
- No
- Unknown

26. If yes, please specify date:

______________________________

27. Have you ever received the pneumonia shot called Prevnar 13?

- Yes
- No
- Unknown

28. If yes, please specify date:

______________________________

29. Do you currently have any specific food allergies/intolerances?

- [ ] Yes
- [ ] No

30.

| | Food Allergy/Intolerance | Symptoms Experienced |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

31. Do you currently have any specific drug allergies/intolerances?

- [ ] Yes
- [ ] No

32.

| | Drug Allergy/Intolerance | Symptoms Experienced |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

33. Do you currently have any specific chemical allergies/intolerances?

- [ ] Yes
- [ ] No

34.

| | Chemical Allergy/Intolerance | Symptoms Experienced |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

35. Do you currently have any specific insect allergies/intolerances?

☐ Yes ☐ No

36.

| | Insect Allergy/Intolerance | Symptoms Experienced |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

37. Social History: Do you currently smoke or vape?

○ Yes
○ No

38. If yes, please specify how long in years?

______________________________

39. Do you have a history of smoking or vaping in the past?

○ Yes
○ No

40. If yes, please specify how long in number of years did you smoke and or vape?

______________________________

41. Do you live with someone that smokes and/or vapes?

○ Yes
○ No

42. If yes, please specify how long you have been exposed?

______________________________

43. Are you routinely exposed to animals/pets?

○ Yes
○ No

44. If yes, please specify the animal/pet:

______________________________

45. Are you routinely exposed to mold?

○ Yes
○ No

46. If yes, where?

______________________________________________

47. Are you routinely exposed to fumes/strong odors?

- Yes
- No

48. If yes, please specify where and/or what fume/strong odor?

______________________________________________

49. Are you exposed to chemicals?

- Yes
- No

50. If yes, where/what?

______________________________________________

51. Are you routinely exposed to birds/pigeons/dove/fowl?

- Yes
- No

52. If yes, please list:

______________________________________________

53. What is the current occupation of the patient (if applicable):

______________________________________________

54. Infection History: Have you suffered from any infections in the recent past?

☐ Yes ☐ No

55.

| | Number | Treated with antibiotics? |
|---|---|---|
| Ear infections in the last 12 months | | |
| Sinus infections in the last 12 months | | |
| Episodes of sore throats in the last 12 months | | |
| Episodes of Pneumonia in your lifetime | | |
| Episodes of Bronchitis in your lifetime | | |

56. Have you suffered any other major infections in your lifetime and approximate date experienced/treated:

☐ Yes ☐ No

57.

| | Infection | Date Experienced | Date Treated | Treated with antibiotics? |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

58. **Have you been treated with any oral or systemic steroids in the last year with the approximate date and condition for which the steroids were prescribed for:**

☐ Yes ☐ No

59.

| | Steroid Name | Dosage/Frequency | Date/s Used | Reason for Use |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

60. **Have you been treated with any antibiotics in the last 12 months?**

☐ Yes ☐ No

61.

| | Antibiotic Name | Dosage/Frequency | Reason for Use |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |

62. **Review of Systems: Please check any signs/symptoms/conditions that you currently experience:**

Constitutional:
☐ Fatigue ☐ Night Sweats ☐ Chills ☐ Fevers

Respiratory:
☐ Shortness 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 ☐ Loss of Taste

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

63. **Please specify other signs/symptoms/conditions that you currently experience:**

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

64. **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

________________________________________

Signature

# 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** ____________________

**Phone Number:** ________________________

- ○ **Other (name)**: ________________________

**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*