PATIENT DATA FORM

Patient's

Last Name: ______________________________ First Name: __________________________ MI: __

Address: ____

City: ______________________________ State:______________ Zip Code: __________

Date Of Birth: ____________ S.S #_________________________ Sex: _______Marital Status:_______(S/M/D/W)

Home Phone: ______________________________ Work Phone: ______________________________

Cell Phone: ______________________________ Email: ______________________________

Emergency: ______________________________ Em. Phone: ______________________________

Referring Dr.: ______________________________ Referring Dr's #: ____________________________

Pharmacy Name:____________________________ Pharmacy number: ___________________________

======**Primary Insurance Coverage**========================**Secondary Insurance Coverage**==========

Insurance Co.:______________________________ Insurance Co.: ______________________________

Insured Name:______________________________ Insured Name: ______________________________

Relationship: _____________ DOB: ____________ Relationship: _____________ DOB: ____________

Co-Pay amount: ________________________ Co-Pay amount: ________________________

Policy Number: ________________________ Policy Number: ________________________

Group Number: ________________________ Group Number: ________________________

Employer: ______________________________ Employer: ______________________________

Prescription Plan Coverage:____________________ Prescription Plan Coverage: ____________________

============**Guarantor Information**===

***Guarantor is the person responsible for any outstanding bills that insurance does not cover.**

Guarantor: ____

Address: ____

City: ______________________________ State: _______ Zip Code: ____________

Phone Number: ____________________________ Misc.: ______________________________

Patient's Authorization

I authorize **Advanced Asthma, Allergy, & Sinus Center** to apply for benefits on my behalf for services rendered by **Advanced Asthma, Allergy, & Sinus Center.** I request that the information I have reported, with regard, that my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy this authorization be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

____ ______________________

Signature of Patient/Guarantor Date

Financial and Appointment Policies

In order for us to provide the best service to our patients, we are providing the following updated policies. Please read, sign, date and return to the front desk.

Financial Policy

I acknowledge that I am responsible for my co-payment at the time of service. I am responsible for any deductibles or non-covered services and any outstanding balance on my account to be paid within thirty (30) days upon receipt of statement.

Referrals

If I do not provide a required referral for my office visit, my appointment will be rescheduled. The office staff will not call my primary care physician to obtain a referral because it is my responsibility.

Cancellation Policy

Effective January 1, 2017, a 24-hour notification is required should I need to cancel or reschedule my appointment. Failure to show for an appointment+ without notification will generate a $25.00 fee, which will be my responsibility. This is not covered by the insurance and I will be fully responsible for this charge.

Medical Records

In accordance with Maryland Law, there is a charge for copying medical records. This charge is $22.88 (includes administration fee). The price per copied page is .50 cent per page. The cost of mailing medical records is the actual postage value. Medical records to your physician are a courtesy. Medical release form from the requesting physician needs to be faxed from their office for this courtesy to apply.

Completion of FMLA, Disability forms and letter fees

There is a $30.00 charge for any kind of **Employment/ Disability Forms** *(EXAMPLE: FMLA forms*). **SCHOOL FORMS** - $15.00 per patient. Please allow **FORMS** 72 HOURS to be completed.

There is also a charge for all letters drafted by our office at your request. The cost for extensive letters is $50.00. Please allow up to TWO (2) Weeks for **LETTERS** to be completed. Payment must be made in full prior to releasing the letter.

I have read the above policies, understand and agree to comply.

______________________________________ ______________________________

Patient/ Guardian signature **Date**

Advanced Asthma, Allergy & Sinus Center
9450 Marlboro Pike, Suite 19, Upper Marlboro, MD 20772
Office: 301-599-5401 Fax: 301-599-5403

NOTICE OF PRIVACY PRACTICES

YOUR PROTECTED HEALTH INFORMATION

Our practice is required by the Federal Privacy Rule to maintain the privacy of your health information that is protected by the rule, and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We are required by the terms of the notice currently in effect.

This office reserved the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will post changes in our waiting room area.

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing and insurance information.

Consent for Care

I, with my signature. authorize AAASC, and any employee working under the direction of the physician, to provide medical care for me, or the patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or identified person) and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment, or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

How We Use Your Patient Health Information

Your health information will be used for treatment, payment, and health care operations, including administrative purposes and evaluation of the quality of care that you receive.

Treatment: Information obtained by our physician in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. The sharing of your health information may progress to others involved in providing care. For example, we may disclose information to other health care providers who are participating in your treatment, or to pharmacists who are filling your prescriptions. It is our policy not to discuss your healthcare with family members except in the event of an emergency, or if there is and urgent situation and we are not able to reach you.

Payment: Your health care information will be used in order to receive payment for services rendered by this office. We will submit bills with accompanying documentation that identifies you, your diagnosis, and procedures performed to your health insurance carrier.

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPPA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. RAAA-AC2: lm-07/03

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Use and Disclosure of Protected Health Information

PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Acknowledgement of Notification

The educational pamphlet "Notice of Privacy Practices" provides information about how Advanced Asthma, Allergy and Sinus Center may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act.

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care options. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our Notice of Privacy Practices.

Patient/Guarantor Signature ______________________ Date ________

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance Carrier benefits be made on my behalf to Advanced Asthma, Allergy and Sinus Center for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and it's agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Patient/Guarantor Signature ______________________ Date ________

Consent for Care

I, with my signature. authorize AAASC, and any employee working under the direction of the physician, to provide medical care for me, or the patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment, or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Patient/Guarantor Signature ______________________ Date ________

Print Full Name ______________________ Date ________

NEW PATIENT REVIEW OF SYSTEMS

Please Complete This Form To Ensure That We Have The Most Up To Date **PAST & PRESENT** Medical History. Thank You!

Patient Name: ____ D.O.B: ___________________ D.O.S: ____________

EARS:

Ear Pain	O Yes	O No
Ear Pressure	O Yes	O No
Dizziness	O Yes	O No
Ringing In Ears	O Yes	O No
Discharge	O Yes	O No
Noise Exchange	O Yes	O No
Hearing Loss	O Yes	O No
Lightheadedness	O Yes	O No

NOSE:

Injury	O Yes	O No
Surgery	O Yes	O No
Blockage	O Yes	O No
Headache	O Yes	O No
Post Nasal Drip	O Yes	O No
Discharge	O Yes	O No
Bleeding	O Yes	O No
Snoring	O Yes	O No

NOSE:

Unable To Smell	O Yes	O No
Sinusitis	O Yes	O No
Sleep Apnea	O Yes	O No
Using CPAP?	O Yes	O No

THROAT:

Soreness	O Yes	O No
Difficulty Swallowing	O Yes	O No
Painful Swallowing	O Yes	O No
Lump In Throat	O Yes	O No
Hoarseness/ Change in Voice	O Yes	O No

ALLERGY

Hay Fever	O Yes	O No
Asthma	O Yes	O No
Skin Test	O Yes	O No
Allergy Shots	O Yes	O No
Eczema	O Yes	O No
Dry Skin	O Yes	O No

Name: ______________________________

EYES:

Watery Eyes	O Yes	O No
Blind Spots	O Yes	O No
Light Sensitive	O Yes	O No
Blurry/Visual Loss	O Yes	O No
Glasses/ Contacts	O Yes	O No
Cataracts	O Yes	O No
Dry Eyes	O Yes	O No

CARDIOLOGY:

Chest Pain	O Yes	O No
High Blood Pressure	O Yes	O No

RESPIRATORY:

Cough	O Yes	O No
Pneumonia	O Yes	O No
Shortness of Breath	O Yes	O No

NEUROLOGY:

Stroke	O Yes	O No
Weakness	O Yes	O No
Headache	O Yes	O No
Seizures	O Yes	O No

HEMATOLOGY/LMPH

Bruising	O Yes	O No
Bleeding	O Yes	O No
Plavix Usage	O Yes	O No
Coumadin Usage	O Yes	O No
Aspirin Usage	O Yes	O No
NSAID Usage	O Yes	O No
Clotting Problems	O Yes	O No

CONSTITUTIONAL:

Fever	O Yes	O No
Weight Loss	O Yes	O No
Fatigue	O Yes	O No

MUSCULOSKELETAL:

Aches	O Yes	O No
Weakness	O Yes	O No
Arthritis	O Yes	O No

New Patient History

Name: ______________________ Birth Date: ______________ Today's Date: ______________

Please describe in a few words why you are here? ____________________________________

Occupation? If child, what grade?____________________________________

Medications

What medications do you take on a daily or frequent basis, prescription and non-prescription, with doses if known. Include all pills, sprays, inhalers, and supplement. ____________________________________

Allergies

List any allergies to medications the nature of the reaction, and how long ago:

Environmental History (check one)

Do you live in a [ ] single family house, [ ] townhouse, [ ] or apartment?

Do you have carpet in the bedrooms? **[ ] yes** **[ ] no**

Do you have carpet in most of the house? **[ ] yes** **[ ] no**

Do you have central air conditioning? **[ ] yes** **[ ] no**

If you have a basement, has there ever been any mold damage? **[ ] yes** **[ ] no**

Do you have or are you around pets **[ ] yes** **[ ] no**

List all pets (indoor & outdoor) or animals you are frequently around:

____

Does anyone who lives in the home smoke? **[ ] yes** **[ ] no**

If patient is a young child, are they at the home during the day, in school, or with another caregiver?

[ ] yes **[ ] no** **if yes, please state which:**____________________

Allergy History

Have you ever been diagnosed with asthma, allergic rhinitis (hay fever, "allergies"), or eczema?

[ ] asthma **[ ] allergic rhinitis (hay fever, "allergies")** **[ ] eczema** **[ ] N/A**

When you were a young child, did you have allergies, asthma, or eczema? **[ ] yes** **[ ] no**

Have you ever been allergy tested **[ ] skin or [ ] blood?** When and what were you allergic to?

____

Have you ever been on allergy immunotherapy/shots **[ ] yes** **[ ] no**

Have you ever had a reaction to **[ ] Food?** **[ ] Latex** **[ ] Insect Stings**

If you do have allergies, what medications have you tried, and did they help? ____________________

____

Initiating/Exacerbating Factors (things that make symptoms worse)

Check those that apply

	Nasal (nose)	Ocular (eye)	Chest	Dermal (skin)
Day				
Night				
Outdoors				
Indoors				
Strong Odor				
Smoke				
Mowing Lawn				
Raking Leaves				
Cleaning House				
Cat				
Dog				
Menstrual Cycle				
Spring				
Summer				
Fall				
Winter				

Family History

Does anyone in your close and distant family have: please check who. (*Note: M = Maternal Relative, P = Paternal Relative*)

	Mom	Dad	Sis.	Bro.	M. Aunt	M. Uncle	P. Aunt	P. Uncle	M. G-Mother	M. G-Father	P. G-Mother	P. G-Father
Asthma												
Allergies												
Eczema												
Sinus Problems												
Heart Disease												
Diabetes												
Cancer												

Past Medical History

What medical problems do you have?

	Current	Past
Eye Disease	[ ]	[ ]
Nasal Polyps	[ ]	[ ]
Croup	[ ]	[ ]
Emphysema	[ ]	[ ]
Heart Disease	[ ]	[ ]
Gastroesophageal reflux	[ ]	[ ]
Migraines	[ ]	[ ]
Hypertension	[ ]	[ ]
Thyroid Disease	[ ]	[ ]
Diabetes	[ ]	[ ]

Have you had [ ] nasal/sinus surgery? [ ] tonsillectomy/adenoidectomy? [ ] ear tubes?

If so, approximately when? ______________________________

Have you ever had surgery? If so, when and what type? ______________________________

____

Have you ever been hospitalized overnight for reasons other than surgery? If so, please list.

____

____

Have you ever had to visit the emergency room for any reason other than what is listed above?

If so, please list.____

____

If patient is a child, was the born premature? ____

Have you ever been a smoker? If so, how many packs per day did/do you smoke, how many years and did you quit?

____

If you have frequent Asthma: _______ N/A

Diagnosis of asthma made ________ years ago (or at age: _____)

# of courses of antibiotics in the past year: ______________

# of Sinus infections in the past year: __________

# of ER visits for asthma per year: ____

# of courses of Prednisone for asthma: _________

# of missed work/school days per year: ________

# of Ear infections in the past year: ____________

Last sinus CT scan date (if any): ______________

Last ER visit: ______________________________

Last course: _______________________________

Do you have a spacer for your inhaler: _________ Do you use it? ____________

Review of Systems:

Please check problems you have had recently (within the past 6-12 months)

________ Loss of Vision

________ Itchy/Watery/Red Eyes

________ Difficulty Swallowing

________ Hoarse Voice

________ Nosebleeds

________ Sneezing

________ Nasal Congestion

________ Post Nasal Drip/Drainage

________ Headaches

________ Coughing

________ Wheezing

________ Shortness of Breath

________ Coughing up Phlegm/Blood

________ Palpitations/ Irregular Heartbeat

________ Swelling of Ankles

________ Heartburn

________ Constipation

________ Bitter/Acidic Taste

________ Rash

________ Hives

________ Swelling

________ Dryness/Itching (skin)

________ Depression

________ Sleeping Poorly

________ Currently Pregnant or Plan to be in the near future