COLUMBIA
ALLERGY and ASTHMA SPECIALISTS

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New Patient Form

Today's Date:_____

Name:_____Birth Date_____ Social Security #_____
Address_____ City_____ ST_____ Zip_____
Marital Status: __single __married __divorced __widowed/widower __domestic partner
Home # _____ Cell # _____Email _____
Employer _____ Work Phone _____

Emergency Contact:_____Relationship_____
Home #_____Work #_____ Cell/Other #_____

Responsible Party or Bill to Information:
Full Name_____Relationship_____ Birth Date_____
Address if different from above _____
Home # _____ Work # _____ Cell_____SS#_____

Primary Insurance:
Insurance Carrier _____Policy #_____Group#_____
Subscriber's Name _____DOB_____ SS#_____
CoPay amount $_____

Secondary Insurance:
Insurance Carrier _____Policy #_____Group#_____
Subscriber's Name _____DOB_____ SS#_____

Primary Physician:_____ Phone_____

How did you learn about us: __Friend __Relative __Yellow Pages __ Physician __ Insurance __Website__Facebook

Chief Complaint:_____
How long has this been a problem?_____
Past Medical and surgical history:_____

Current Medications: Prescription, Inhalers, over the counter, supplements etc.

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____

Patient Name and DOB:_____

What is your preferred pharmacy?_____

Do you have any medication allergies? ___Y ___N
What medications and reaction?_____
_____
Do you have any food allergies? ___Y___N What foods?_____
Do you have any insect allergies?___Y___N

Have you ever had allergy testing before?___Yes ___No
If yes, name of previous allergist and when?_____
Have you ever been on allergy shots before?___Y___N If yes, how long?_____

Family history: Please mark any family members that have experienced any of the following conditions: asthma, allergies, sinusitis, bronchitis, COPD, emphysema, migraines, eczema or hives
__ mother __father __brother __sister __aunt __uncle
__grandmother __grandfather N/A adopted___

Living/Work Environment:

Do you have any pets? __Y __N If yes, what kind and how many? Inside the home?
_____
Home or apartment?_____ Type of heat?_____ Air condition? _____
Any filters inside the home? _____ Floor types? __carpet __hard wood __vinyl __tile
Do you have curtains? ____ Blinds? ___ Cleaning frequency_____
Are there any smokers in the home? _____ If yes, how many? ____
Plants? __ How many? ___
Do you have hypoallergenic mattress covers and pillows on your bedding? __Y __N
Work/School Environment?_____
What is your worst time of year? ___Spring ___Summer ___Fall ___ Winter
Triggering factors:
__heat __cold __night __day __foods __cleaning agents __laughter
__candles __cats __dogs __trees __grass __lawn mowing __dust
__metals __weeds __smoke __illness __weather changes __wind
__other please list _____

Do you smoke? __Y __N If yes, how many years? ____ How much per day?_____

Review of systems:

Ears	Eyes	Nose	Throat	Sinus
Popping	Tearing	Runny	Pain	Pain
Fullness	Itch	Itch	Itch	Drainage
Recurrent Infection	Redness	Sneeze	Redness	Pressure
Tubes	Change in vision	Bleeding	Hoarseness	Infection
Hearing Loss	Other	Blockage	Tonsillectomy	Other
Other		Polyps	Adenoidectomy	
		Loss of smell	Other	
		Other		

Skin	Respiratory	Gastrointestinal
Itch	Cough	Nausea
Burn	Wheeze	Vomiting
Rashes	Shortness of breath	Reflux/heartburn
Hives	Exercise	Food Intolerance
Eczema	Night cough	Other
Dryness	Day cough	
Other	Other	

Patient Name and DOB:_____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent and authorization for COLUMBIA ALLERGY and ASTHMA SPECIALISTS, to provide examination, treatments, and services by a licensed provider to myself/designee. I realize and certify that no guarantee or assurance has been made as to the results that may be obtained for such examinations, treatments, and services.

ASSIGNMENT AND RELEASE

I hereby authorize my insurance company to pay benefits directly to COLUMBIA ALLERGY and ASTHMA SPECIALISTS, or its designee, for services rendered, and agree that I am financially responsible for non-covered services. I also authorize COLUMBIA ALLERGY and ASTHMA SPECIALISTS, to release any and all requested information pertaining to treatment necessary to process claim(s) benefits. (Physician, Insurance company, Attorney, etc)

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier as a courtesy to you. Questions and/or concerns about the bill and payment polices should be addressed with your provider.

I understand that account balances remaining due 90 days and more after the date services were provided will be subject to a 1.5% finance charge per month and any cost incurred in the recovery of those charges including collection costs and reasonable attorney's fees will be my responsibility. Customized payment programs may be available on a pre-arranged basis.
I understand that it is my sole responsibility to understand my insurance coverage, and that I will independently verify my benefits with my insurer. Any balance that remains unpaid after my insurer has processed my claims, minus any contractual discount that COLUMBIA ALLERGY and ASTHMA SPECIALISTS is required to extend to me, is my full responsibility.

I have read the above information and understand that ultimately it is my sole responsibility for the payment of my account.

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITES

I, _____, have been provided access to, and have been offered a copy of, the notice of privacy practices followed by COLUMBIA ALLERGY and ASTHMA SPECIALISTS, and I was also provided with a copy of the summary of the Privacy Practices and Patient Rights and Responsibilities followed by COLUMBIA ALLERGY and ASTHMA SPECIALISTS. I have read and understand Assignment and Release and Financial Policy Statement as set forth above. I have had an opportunity to read all these documents and ask questions.

I consent and agree to all the terms and conditions as set forth in these documents.

Signature of Patient:_____

If patient is a minor, Signed for Patient by:_____Relationship:_____

Today's Date:_____**Witness:**_____