Moonhee Lee, M.D.

Diplomate American Board of Allergy and Immunology
Diplomate American Board of Internal Medicine

DATE: _____

PATIENT INFORMATION

Patient Name: First_____ MI_____ Last_____ Sex: _____

Date of Birth: _____/_____/_____ Age: _____

Address: _____Apt # _____ City_____ State_____ Zip _____

Phone: Primary: _____ Secondary _____

Primary Doctor: _____

Employer: _____ Occupation: _____

REFERRAL SOURCE

□ Friend/Family Member □ Insurance Company □ Web Search □ Another Physician/Provider _____

EMERGENCY NOTIFICATION

1. Name: _____Relationship to Patient: _____

Phone: _____

2. Name: _____ Relationship to Patient: _____

Phone: _____

Consent to the Use and Disclosure of Health Information For Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

-a basis for planning my care and treatment
-a means of communication among the many health professionals who contribute to my care
-a source of information for applying my diagnosis and surgical information to my bill
-means by which a third-party payer can verify that services billed were actually provided
-a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to use of my information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Please Initial

Accepted _____

OR

Denied _____ _____

Signature Date

NAME: _____ D.O.B. _____ DATE: _____

ALLERGY AND ASTHMA CENTER OF SOUTHWEST ARLINGTON

Please circle symptoms that apply.

NOSE

Runny	Blocked
Stuffy	Sneezing
Loss of smell	Itchy

EYES

Watery	Itchy
Puffy lids	Red
Dark circles	

EARS

Popping	Blocked
Hearing loss	Itchy
Frequent Infection	

THROAT

Sore	Itchy
Drainage	

CHEST

Wheeze	Cough
Phlegm	Pain
Tightness	
Shortness of breath	

OTHERS

Skin rash	Nausea
Headache	Fatigue
Abdominal pain	

WORST SEASON

Spring	Summer
Fall	Winter
All year	

CURRENT MEDICATIONS

DRUG ALLERGIES

PETS AT YOUR HOME

Cat	Horse
Other_____	Dog

ANY ALLERGY OR ASTHMA IN YOUR FAMILY? **Y N**

WHO?

Father Mother Sibling Children

Are immunizations current? **Y N**

ALLERGY AND ASTHMA CENTER OF SOUTHWEST ARLINGTON

MOONHEE LEE, M.D.
DIPLOMATE
- **AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY**
- **AMERICAN BOARD OF INTERNAL MEDICINE**

PLEASE READ THIS CAREFULLY BEFORE SIGNING

Every effort is made to obtain detailed and accurate insurance benefit information on each individual patient that comes to our office. Unfortunately, the insurance companies do not guarantee that the coverage and benefit information they give is accurate and state this at the beginning of every call we make to them. Although rare, errors are occasionally made by them. We cannot be responsible for this and the balance of whatever the insurance company says you owe will be due from you. Additionally, you are responsible for telling us if your insurance has changed before you are seen or treated, because you may require a referral, a deductible, a waiting period on certain diagnoses and/or have a filing deadline on the new policy. You are responsible for payment if you do not inform us of new insurance prior to services. To avoid any misunderstandings regarding future account balances, we require you to sign this consent prior to rendering services to you if you want us to file your insurance for you. Thank you for your cooperation.

I am aware that the insurance benefits that were obtained on my or my family member's behalf are estimates of payments and are not guaranteed by the insurance company. I agree to pay the amount due stated on the insurance company payment explanation after it is processed by them, if it was not fully collected at the time of my visit.

_____ _____

Patient Name **(PLEASE PRINT)** Date

_____

Patient or Guardian **Signature**
(PLEASE SIGN YOUR SIGNATURE)