West Texas Allergy

Miguel P. Wolbert, M.D.
Paula Baker, CPNP Misty Fortner, PA-C
Dorane Thornton, PA-C
5000 Briarwood Avenue
Midland, Texas 79707
Office (432) 682.5385 Fax (432) 682.1265

Date Patient Called: _____

Appointment Date & Time:
_____
_____

Patient Information

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____
Last First Middle Initial

Soc. Sec. #:_____Birthdate: _____

Home Address:_____

☐ Male ☐ Female

Email Address: _____

Patient Employed by: _____ Occupation: _____

Person Responsible for Account (if different from person above):

Name: _____ Social Sec. #: _____

Relationship to Patient_____ Birthdate:_____ Phone: _____

Address (if different from above):_____

Soc. Sec # of insured: _____ Employed by:_____

Insurance Company: _____ Insurance Address: _____

Group No. _____ Subscriber ID: _____

Is patient covered by additional insurance: ☐ Yes ☐ No

Secondary Insurance Subscriber Name: _____

Relationship to Patient: _____ Birthdate: _____

Soc. Sec. #_____

Address(if different from above):_____

Phone: _____ Employed by: _____

Insurance Company: _____ Insurance Address:_____

Group No. _____ Subscriber ID: _____

Over for more.

West Texas Allergy

Patient Information Continued

Name: _____
Last First Middle Initial

Soc. Sec. #:_____Birthdate: _____

Did a physician refer you to see us? ( ) Yes ( ) No

If yes, Doctor's Name: _____

If a physician did not refer you, how did you hear about us? _____

Primary Care Physician's Name: _____

Reason for Visit: _____

How long have you had this condition?: _____

Describe the most distressing symptoms you feel are caused by your allergy:

_____

_____

_____

List all medications you have tried in the past for allergy (all oral, topical and nasal sprays) and the response you had to each:

_____ _____

_____ _____

_____ _____

Known Allergies to Medications (List names and symptoms you had):

_____

_____

All Current Medications (include allergy medications):

_____

_____

_____

_____

_____

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Patient Instructions for Skin Testing

Based upon the findings of Dr. Wolbert during your appointment, it may be determined that you will need allergy skin testing. Should that be the case, we ask that you read the information below and make sure not to take any of the listed medications at least three days prior to your appointment as we will do the skin testing the same day as your appointment. **Please allow extra time for your initial appointment in the event testing is necessary.**

Aeroallergen skin testing is done using the prick and intradermal methods. These methods are used by board-certified allergists and are accepted as the standard method for the diagnosis of allergic disease. Skin testing is not painful and is the most cost-effective method of allergy testing available. Allergy testing can be safely performed at any age.

Depending on the history of your allergy symptoms you will be tested to common inhalant allergens including pollens, pet dander, molds and dust mites. Occasionally, skin tests to common food allergens will also be included. Should your skin prick tests be negative, we might also perform intradermal skin tests to be sure that important allergen sensitivities are not missed. However, intradermal testing is not done on young children.

IMPORTANT: Certain medications must be stopped prior to allergy skin testing.
Please do not take any medicines that contain antihistamines for at <u>least 3 days prior</u> to your appointment.

Common antihistamines include:

- Clarinex, Claritin, Allegra, Zyrtec, Astelin, Actifed, Atarax, Benadryl, Dimetapp, Dymista, Xyzal, Patanase, Astepro, Trinalin, Periactic, Phenergan, Triaminic
- Decongestant/antihistamine combination medications
- Any over-the-counter allergy medicines or cold & cough remedies
- Any over-the-counter sleep aids − they usually contain sedating antihistamines
- Some medications for dizziness and anti-depressants (tricyclic antidepressants) can also contain antihistamines.

You should continue to take as prescribed the following medications:

- Antibiotics
- All asthma medications
- Oral steroid/prednisone
- Prescription nose sprays, with the exception of Astelin, Astepro, Patanase, Dymista
- Decongestants that are not combined with an antihistamine
- All of your other non-allergy medications

Should you have a question about a specific medication, please feel free to call us at 432.682.5385.

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RELEASE OF INFORMATION: I hereby authorize the physician and/or supplier to release any information required to process this claim and claims for any future treatment unless rescinded by me in writing.

Date: _____ Signature: _____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to West Texas Allergy which includes: Dr. Wolbert, M.D., Paula Baker, C.P.N.P. and Misty Fortner, P.A.-C for services performed. **I also understand that any and all services (including allergy extract) that are not covered by the insurance will by my responsibility.**

Date: _____ Signature: _____

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made on my behalf to West Texas Allergy for any services furnished by the physician, physician assistant and/or nurse practitioner. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "the other health insurance" is indicated in box 9 of the HCFA-1500 form or elsewhere on the approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determined of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services.

Date: _____ Signature: _____

Over for more.

West Texas Allergy

REQUEST FOR CONFIDENTIAL COMMUNICATIONS
&
ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES

Name of Patient: _____
(please print)

Date of Birth: _____

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I request that all communications to me (by telephone, mail, electronic mail or otherwise) by West Texas Allery and staff are handled as follows:

• For WRITTEN Communication Address to:

_____

_____

• For ORAL Communication Call:

Home: _____ May we leave a message? Yes No

Work: _____ May we leave a message? Yes No

Cell: _____ May we leave a message? Yes No

• Electronic Mail Communication to E-mail Address:_____

If the address above is not your home address OR is not a street address, please provide us with a street address for purposes of ensuring payment:

_____

_____

• I wish to place the following restrictions on disclosure of my health information:

_____

Patient (Guardian) Signature: _____Date:_____

Relationship to Patient: _____