Cranberry Allergy Asthma and Clinical Immunology

119 VIP Drive, STE 204 Wexford, PA 15090
Phone: (724) 935-1111 Fax: (724) 704-7832

Today's Date: _____ Home Phone: _____

Name: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M / F Age: _____ Birth date: _____ Marital Status: _____

Patient's Occupation & Employer and/or School *(if student*): _____

Spouse's Occupation and Employer:_____

If patient is minor: Father's Occupation & Employer:_____

Mother's Occupation & Employer:_____

Please tell us how you learned about our clinic? _____

Referring Physician: _____ General office location:_____

Primary Care Physician: _____ General office location:_____

Emergency Contact: _____Relation to patient:_____ Phone: _____

Communication Preference: Do you prefer Appointment Reminders via automated (*please circle one of the following options:*) **Home phone call Cell phone call Email or Text Message ?**

If by email, please enter the email address here: _____

Payment and Insurance Information –*We will need to see your **photo ID** and make a copy of your **insurance card.***

Primary Insurance: _____ **Member ID #**_____

Group Name: _____ Group/Plan # _____

Policy Holder/ Subscriber Name: _____ **Date of Birth:**_____ **Relation to patient:** _____

Address (*If different from patient*):_____ **City:**_____ **State:**_____ **ZIP:** _____

***Secondary Insurance** (if applicable):* _____*Policy or ID#*_____

*Group Name:*_____ *Group/Plan #* _____

*Policy Holder Name:*_____ ***Date of Birth:***_____ *Relation to patient:* _____

Do you have a Pharmacy Benefit Manager/ PBM? Circle: Yes / No; show copy of separate Pharmacy ID Card if applicable

Do you have a preferred pharmacy? (*provide name and ideally closest zip code***):**_____

Financially Responsible Party ***(Please designate the party to whom any bills should be addressed and sent):***

Name:_____ **Relation to patient:**_____ **Phone:**_____

Address (*If different from patient)*:_____ **City:**_____ **State:** _____ **ZIP:** _____

Additional Information: Preferred Language: _____English or _____Other (*please specify*):_____

Is the reason for today's visit the result of an injury? If yes, date of injury:_____; Was it employment related? Yes / No;

Details:_____

Assignment and Release

I, the under signed, certify that I (or my dependent) have insurance coverage with the above noted insurance company. I authorize Cranberry Allergy Asthma and Clinical Immunology to apply for benefits on my behalf for services rendered and assign payment of these benefits to the doctor. I authorize Cranberry Allergy Asthma and Clinical Immunology to use and disclose my health information for treatment, payment, and health care operations purposes consistent with its Notice of Privacy Practices.
I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions and permit a copy of this authorization to be used in place of the original.

Signature: _____ Relationship to patient: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

This consent authorizes Cranberry Allergy Asthma and Clinical Immunology to use or disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. Cranberry Allergy Asthma and Clinical Immunology has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may obtain and review our current notice prior to signing this acknowledgment and consent.

Revisions to Notice of Privacy Practices. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. Copies of revised notices will be available at the reception desk and also may be obtained by submitting a written request to our privacy officer.

How to contact our privacy officer

Mail:	Cranberry Allergy Asthma and Clinical Immunology Attention: Privacy Officer
Address:	119 VIP Drive Suite 204 Wexford, PA 15090
Telephone:	(724) 935-1111
Facsimile:	(724 704-7832

I acknowledge that I received and/or was given the opportunity to review the Notice of Privacy Practices for Cranberry Allergy Asthma and Clinical Immunology.

_____	_____	_____
Name of patient	**Signature of Patient**	**Date of receipt**
_____	_____	_____
Name of personal representative (if applicable)	**Signature of Personal Representative**	**Relationship to patient (or other authority)**

**** For Office Use Only**; when efforts to obtain acknowledgment of receipt of notice are unsuccessful*

Good faith efforts to obtain acknowledgment of receipt of notice of Privacy Practices

_____
Name of patient

_____ _____
Name of personal representative (if applicable) Relationship to patient (or other authority)

I provided the above named ☐ patient ☐ personal representative with the Notice of Privacy Practices for Cranberry Allergy Asthma and Clinical Immunology.

Describe how notice was provided:
☐ Offered copy and patient or personal representative refused to accept delivery
☐ Offered copy and patient or personal representative accepted delivery
☐ Other _____
_____

Describe efforts to obtain signature on acknowledgment of notice form:
☐ Patient or personal representative was asked to sign form and refused.
☐ Other _____
_____

_____	_____	_____
Signature of staff member	**Printed name of staff member**	**Date**

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Permission to Share Protected Health Information with Designated Individuals

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule is a Federal law that sets national standards for how health plans, health care clearinghouses, and most health care providers are to protect the privacy of a patient's health information. **This form gives you the opportunity to designate specific individuals with whom we may discuss your health information.** For example, your spouse, your care givers, other family members, specific friends who are involved in your health care, your parents if you are over the age of 18 years and the parents of emancipated minors. You may revoke this permission at any time- see below.

In the event that you are a parent or legal guardian of the patient please provide us with the names of any additional individuals who are involved with your child's care (eg. Babysitter, nanny, grandparent, etc) with whom we may discuss his/her protected health information.

Name of individual	Relationship	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____

(check all that are applicable):

□ **All records**	□ Laboratory/ Pathology results	□ X-ray/Radiology records
□ Billing records	□ History / exam findings	□Treatment Plan
□ Medications/prescriptions	□ Consult Reports	□ Physician Recommendations
□ Pulmonary Testing	□ **Allergy test results**	

□ Other (specifically)_____

Note: HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise specified here: **Do not release: □ HIV □ Mental Health □ Drug & Alcohol**

Please note, the provider(s) and/or associates at Cranberry Allergy Asthma and Clinical Immunology may attempt to contact you/the patient through one of your contacts or household members. If so, we will use our best professional judgment and discuss only the information that the person involved needs to know about your/ the patient's care or payment of care.

By signing below, I am expressing that I understand that this authorization will expire one year from the date of signature and if I wish to revoke this permission to any or all of these individuals, it will be my obligation to notify Cranberry Allergy Asthma and Clinical Immunology of this decision in writing.

Patient's name (print): _____ Date of signature:____ /____ /____

Signature of patient/parent/ legal guardian:_____

If signee is not the patient, please indicate relationship/ authority:_____

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Medical Questionnaire

Date: _____ Name: _____ Date of Birth: _____ **Age**: _____

Reason for visit: _____

Current Medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies to Medications: (*please specify the name of the drug and the reaction)*

_____ _____
_____ _____
_____ _____

Medical History: *(please note conditions for which you are being treated or have been treated for in the past)*

- □ High blood pressure
- □ High cholesterol
- □ Thyroid disease/ hypothyroidism
- □ Diabetes
- □ Asthma ___ outgrown; ___ active
- □ Emphysema/ COPD
- □ Obstructive sleep apnea
- □ Gastro esophageal/ Acid reflux/ Ulcers
- □ Celiac disease
- □ Anemia *(please specify):*_____
- □ Anxiety
- □ Depression
- □ Seizure disorder/ epilepsy
- □ Rheumatoid arthritis
- □ Lupus
- □ Cataracts
- □ Glaucoma
- □ Psoriasis
- □ Eczema/ atopic dermatitis
- □ Osteoporosis
- □ Cancer: __ active; __ in remission (*please specify type*) _____
- □ Food Allergies ___ outgrown; ____ active
- □ Other *(please specify any chronic medical conditions not listed above :*_____
  _____

Previous Surgeries:

- □ Tympanostom tubes/ Ear tubes
- □ Tonsillectomy
- □ Adenoidectomy
- □ Sinus surgery *(please specify type if known:)*_____
- □ UPP/ uvulopalatopharyngoplasty
- □ Appendectomy
- □ Cholecystectomy/ gall bladder
- □ Other(s): _____

Do you live or work with or spend time with Pets/ Animals?*(Please list):*_____

_____

Family History: *please check condition and circle the relative(s) who has/have it*

- □ Allergic rhinitis/ hay fever **mom / dad / sibling / other**
- □ Asthma **mom / dad / sibling / other**
- □ Emphysema/ COPD **mom / dad / sibling / other**
- □ Atopic dermatitis/ eczema **mom / dad / sibling / other**
- □ Food allergies **mom / dad / sibling / other**
- □ Thyroid disease **mom / dad / sibling / other**
- □ Rheumatoid arthritis/ Lupus **mom / dad / sibling / other**
- □ Cataracts **mom / dad / sibling / other**
- □ Glaucoma **mom / dad / sibling / other**
- □ Celiac disease/ gluten enteropathy **mom / dad/ sib/ other**
- □ Osteoporosis **mom / dad / sibling / other**
- □ Hypertension **mom / dad / sibling / other**
- □ High cholesterol **mom / dad / sibling / other**
- □ Diabetes **mom / dad / sibling / other**
- □ Dementia **mom / dad / sibling / grandparent**
- □ Other *(please list*)_____
- □ _____
- □ _____

Symptom Review: *Have you RECENTLY (**in the last few months)** experienced any of the following problems:*

General
- □ recent unintentional weight loss / gain
- □ fevers
- □ chills
- □ night sweats
- □ food sensitivity or reactions
- □ fatigue

Eyes
- □ decreased vision
- □ eye pain
- □ eye itching
- □ eye tearing
- □ swelling of the eye lids
- □ puffiness under the eye

Ears
- □ trouble hearing
- □ persistent bothersome ringing in ears
- □ ear pain
- □ recurrent ear infections or drainage
- □ plugged sensation
- □ recurrent popping

Nose
- □ stuffy nose/ congestion
- □ frequent or persistent nose bleeds
- □ sneezing
- □ nasal itching
- □ runny nose
- □ post nasal drip
- □ recurrent sinus infections
- □ absent sense of smell

Mouth and Throat
- □ itchy throat
- □ frequent sore throats
- □ throat clearing
- □ sensation of something stuck in the throat
- □ difficulty swallowing
- □ pain near teeth or mouth
- □ hoarseness or voice weakness/ changes

Respiratory
- □ cough
- □ wheezing
- □ shortness of breath
- □ chest pain
- □ exercise difficulty
- □ any prior pneumonias? when:_____

Gastrointestinal
- □ heartburn or acid reflux
- □ nausea
- □ vomiting
- □ abdominal pain
- □ new onset constipation
- □ diarrhea

Genitourinary
- □ urinary urgency
- □ urinary frequency
- □ trouble starting flow
- □ blood in the urine
- □ pain with urination
- □ history of kidney problems:_____

Neurologic
- □ dizziness, vertigo, or unsteadiness
- □ weakness *(circle where)* arms / legs / face
- □ numbness: where?_____
- □ tingling: where?_____
- □ headaches: front / back/ sides/ top of head
- □ confusion or memory loss
- □ seizures
- □ tremors

Neck
- □ pain
- □ stiffness
- □ lumps

Musculoskeletal
- □ muscle pain
- □ joint pain
- □ joint stiffness
- □ joint swelling
- □ redness and warmth over joints
- □ please specify location:_____

Integumentary/ SKIN
- □ pimples/ pustules - location:_____
- □ ulcers - location:_____
- □ itching - location:_____
- □ flaking/ peeling - location:_____
- □ redness - location:_____
- □ facial flushing/ blushing
- □ swelling - location:_____
- □ Other:_____

Cardiovascular
- □ blackouts or fainting
- □ heart trouble
- □ palpitations
- □ racing/ fast heartbeats
- □ pain/ pressure in chest

Psychiatric
- □ nervousness/ anxiety/ worry
- □ increased stress (home /work / other)
- □ moodiness/ irritability
- □ sadness
- □ loss of enjoyment of activities
- □ loss of hope
- □ suicidality
- □ feeling like you might harm someone