Asthma & Allergy Care, P.C.
Adult & Pediatric, Asthma, Allergy & Sinusitis

Patient Insurance Questionnaire

Patient's Name: _____ Date of Birth:_____Age: _____
Street Address: _____ Telephone (Home): _____
City: _____ Telephone: (Work): _____
State: _____ Zip: _____ Cell Phone/Pager: _____
Social Security Number: _____ Email Address: _____

Occupation: _____
Patient's Employer/Address: _____
Referring Physician/Address: _____
Additional Physician Reports to: _____
Sex: [ ]Male [ ]Female Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widow
Chief complaint: _____
Other Referral Sources: _____
Emergency Contact:_____ _____

PRIMARY INSURANCE (copy of insurance card is required)	**SECONDARY INSURANCE (copy of insurance card is required)**
Name of insurance company: _____	Name of insurance company: _____
Address: _____	Address: _____
ID or Policy #: _____	ID or Policy #: _____ __
Group #: _____	Group #: _____
Address: _____	Address: _____
Date of birth: _____	Date of birth: _____
Social security number: _____	Social security number: _____
Sex: [ ]Male [ ]Female	Sex: [ ]Male [ ]Female
Effective date of insurance: _____	Effective date of insurance: _____
Who is Subscriber: (check one) [ ]Self [ ]Spouse [ ]Parent [ ]Other: _____	Who is Subscriber: (check one) [ ]Self [ ]Spouse [ ]Parent [ ]Other: _____
If Subscriber is other than Self, complete following: Subscriber's name: _____	If Subscriber is other than Self, complete following: Subscriber's name: _____

FOR RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

I accept responsibility and guarantee payment for all services rendered to me and my family and upon default on any payment due ASTHMA & ALLERGY CARE, I agree to pay all cost of collections including collection agency fees. I understand there is a $10.00 returned check fee should a check be returned for any reason.

I authorize the release of any medical information or other information as is necessary to process claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Asthma & Allergy Care, Dr. _____to apply for benefits on my behalf for covered services rendered by his/her, or by his/her order. I understand it is my responsibility to understand the provisions of my policy and to obtain necessary referrals, and authorizations from my PCP. I request that payment from my insurance carrier be made directly to Asthma and Allergy Care, PC. I understand that I am responsible to pay all charges not covered by my insurance company, and if payment from insurance is not received within 120 days that I will be responsible for the amount due. Any remaining balance on the account after the insurance pays will be due upon receipt of my statement or upon receipt of my explanation of benefits. Charges not payable by my insurance carrier are due immediately. I certify that the information I have reported with regard to my insurance coverage is correct. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature: _____ Date: _____

Patient Health Questionnaire

Patient Name:_____Age:_____
Male:___Female:___Date:_____
Referring Physician/Address/Phone:_____
_____
Why are you seeing us? (Please describe.):_____
_____
_____

1. DO YOU HAVE ANY OF THESE?	**YES**	**NO**
Nasal congestion and/or runny nose	___	___
Itchy or watery eyes	___	___
Frequent sneezing	___	___
Snoring	___	___
Drainage down back of throat	___	___
Frequent yellow or green nasal drainage	___	___
Frequent headache	___	___
Coughing	___	___
Wheezing or shortness of breath	___	___
Diagnosis of asthma	___	___
Past hospitalization for asthma	___	___
Possible reaction to food or drug	___	___
Bee sting reactions	___	___
Rashes or eczema	___	___
Frequent sinus infections/bronchitis	___	___

2. SYMPTOMS OCCUR MOST OFTEN:
Spring___ Summer___ Fall___ Winter___ Year round___

3. SYMPTOMS WORSEN/CHANGE WITH:

___Cold air	___Plants (poison ivy)	___Raking leaves
___Cigarette smoke	___Dusting or cleaning	___Weather change
___Chemicals	___Colds/flu	___Exercise
___Aerosols sprays	___Pets (cat, dog, bird, other)	___Sunscreens
___Cosmetics	___Fresh cut grass	

4. LIST YOUR CURRENT MEDICATIONS # or mg tabs, caps or inhaler puffs Times per day

_____ _____
_____ _____
_____ _____
_____ _____

Previous pets:_____Mice/roaches: ___Yes

7. HOSPITAL VISITS/SURGERIES: _____
_____

8. IMMUNIZATION STATUS: Are your vaccines up-to-date? ___Yes ___No
Describe:_____

9. PAST ALLERGY CARE: _____
10. DO YOU HAVE ALLERGIC REACTIONS TO:

Aspirin: _____	Plants: _____
Sulfites: _____	Soaps/fabric softeners/cosmetics: _____
Medications: _____	Latex rubber: _____
Foods & additives: _____	Vaccines: _____
Insect stings: _____	Other: _____

11. FAMILY HISTORY: Parents:_____
Siblings:_____ Other: _____

12. SOCIAL & WORK HISTORY: Occupation:_____
Work exposure: _____
Skin sensitivities: _____
Sensitivity to chemicals/smells/newspapers: _____
Alcohol usage: _____
Drug usage: _____
Tobacco history: ___Yes ___No Please describe: _____
Secondary tobacco exposure: _____