ALLERGY & ASTHMA CARE, P.A.
10787 Nall Ave., Ste. 200
Overland Park, KS 66211

Patient Information Sheet

Today's Date _____/_____/_____

Patient's Name (Last) _____ (First) _____ (MI) _____

Maiden/Nickname _____ Date of Birth _____/_____/_____ Sex: ☐ Female ☐ Male

Street Address _____ Apt _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Phone Numbers (Home) _____ (Work) _____ Ext _____ (Cell) _____

Email Address _____ @ _____ . _____

Ethnicity: ☐ Caucasian/White ☐ African American/Black ☐ Hispanic/Latino ☐ Asian ☐ Other

Social Security Number _____ - _____ - _____ Driver's License _____ State _____

Primary Care Physician _____ Referred By _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Not Employed ☐ Active Military ☐ Student ☐ Retired

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Spouse's Name (First and Last) _____ Date of Birth _____/_____/_____

Spouse's Phone Number _____ Spouse's Work Number _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Not Employed ☐ Active Military ☐ Student ☐ Retired

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

If Patient is a MINOR, please complete the following section:

Parent 1: ☐ Dr. ☐ Miss. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Rev.

Name (First and Last) _____ Maiden Name _____

Address _____ Apt _____ City _____ State _____ Zip _____

Social Security Number _____ - _____ - _____ Date of Birth _____/_____/_____

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Phone Number _____ Email _____ @ _____ . _____

Parent 2: ☐ Dr. ☐ Miss. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Rev.

Name (First and Last) _____ Maiden Name _____

Address _____ Apt _____ City _____ State _____ Zip _____

Social Security Number _____ - _____ - _____ Date of Birth _____/_____/_____

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Phone Number _____ Email _____ @ _____ . _____

Emergency Contact

☐ **Mark here if same as Parent** ○ Parent 1 ○ Parent 2 ○ Spouse

Name (First and Last) _____ Relation to Patient _____

Address _____ Apt _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Ext. _____ Cell _____

PLEASE COMPLETE INSURANCE INFORMATION ON REVERSE SIDE

Primary Insurance Information (please provide a copy of your insurance card)

Insurance Company _____ Policy Holder's Name (First and Last) _____

Policy Holder's DOB _____ /_____/ _____ Policy Holder's Social Security Number _____-_____-_____

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other Effective Date of Policy _____

Member ID Number _____ Group/Account Number _____

Secondary Insurance Information (please provide a copy of your insurance card)

Insurance Company _____ Policy Holder's Name (First and Last) _____

Policy Holder's DOB _____ /_____/ _____ Policy Holder's Social Security Number _____-_____-_____

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other Effective Date of Policy _____

Member ID Number _____ Group/Account Number _____

I hereby authorize Allergy & Asthma Care, P.A., and its physicians to treat me/my child and to release any and all information to my insurance carrier for purposes of claims administration and evaluation, utilization review and financial audit. I also authorize release of information to my other physicians. These authorizations remain in effect from the date of signing until revoked in writing. I hereby assign to Allergy & Asthma Care, P.A. all money to which I am entitled for medical expense relative to services provided but not to exceed my indebtedness. I understand I am financially responsible to Allergy & Asthma Care, P.A. and its physicians for charges not covered by this assignment.

_____
PRINT Parent/Guardian's Name

_____
PRINT Patient's Name

_____
Parent/Guardian Signature

_____
Patient's Signature

_____ /_____ /_____
Date

_____/ _____/_____
Date

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Allergy & Asthma Care

www.allergycarekc.com

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FINANCIAL POLICY

- All contracted insurance are billed directly to your insurance company as a courtesy of Allergy and Asthma Care, P.A. **Any remaining balances** for non-covered benefits, deductibles, copays, and co-insurances are **your responsibility**. We **require** a copy of a valid credit or debit card to be kept on file. If you choose to put an HSA or Benefits Card on file, a valid credit or debit card is still required to be kept on file as secondary.

- **You will receive one paper statement**; in addition, you will receive an EOB (Explanation of Benefits) from your insurance company explaining the costs incurred and monies due to our facility.

  Your credit or debit card will be charged at least 30 days after the date of your statement to give you the opportunity to pay balance due by another method. It may take up to 3 months or longer for your insurance to process your claim. Therefore, the charge to your credit/debit card may be delayed. We do not charge your card until your insurance company has processed your claim. All accounts that become past due 45 days after your insurance pays, we reserve the right to send your account to a collection agency if the balance is not paid in full within 60 days.

- We have adopted a **NO SHOW** policy that requires at least a 24-hour cancellation notice. Failure to give us a 24-hour notice will result in a $45 charge per patient.

- We accept cash, check, Visa, MasterCard, Discover, American Express, or Money Order. Additionally, you may pay through paymydoctor.com, Instamed.com, or CareCredit.

  A copy of this form will be available at your request. Thank you for choosing us as your provider.

****

I hereby acknowledge that I have read, understand and agree with the policies set forth by Allergy and Asthma Care, P.A., and any change made by me will be made only in writing. I give my authorization for the charge of my valid credit/debit card.

Printed Patient Name _____ Signature _____

Parent/Guardian Signature _____ Date _____ / _____ / _____

Reviewed by _____

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Medical Information Release Form
(HIPAA Release Form)

Patient's Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse _____ Parent 1 _____

Child(ren) _____ Parent 2 _____

School/Other_____ Grandparent _____

_____ _____

[ ] Information is not to be released to anyone.

*This **Release of Information** will remain in effect until terminated by me in writing.*

Messages

Please call:
[ ] my home _____ [ ] my work _____ [ ] my cell number _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ between (time) _____

Pharmacy

Pharmacy Name _____

Location/Intersection _____

Phone number _____

Signed:_____ Date: ____/____/____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

A copy of Allergy & Asthma Care, P.A.'s "Notice of Privacy Practices" has been received.

_____
Patient Name *(Please Print)*

_____ _____
Signature of Patient or Parent/Guardian Date

This acknowledgement also pertains to the following dependents under the age of 18:

_____
Patient Name *(Please Print)*

_____
Patient Name *(Please Print)*

_____
Patient Name *(Please Print)*

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ALLERGY & ASTHMA CARE, P.A.

ALLERGY, ASTHMA AND RELATED DISEASES

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Note: You must bring this questionnaire to your appointment.

(If there is a question you do not understand, place a question mark by it in the margin.)

Name _____ DOB _____ Age _____ Date _____

Preferred Pronoun _____

Person completing questionnaire if not the patient _____ Relationship _____

Spring Fall

circle the symptomatic months: Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec year-round symptoms

Check current and/or recent symptoms ☑: ***(Please be as complete as possible.)***

ROS:

Eyes: ❑itching ❑burning ❑redness ❑watering ❑swelling ❑shiners (dark circles under eyes) ❑dryness ❑discharge ❑visual problems

ENT:

ears: ❑itching ❑pain ❑infections ❑tubes (year(s)_____) ❑popping ❑hearing loss ❑fullness

nose: ❑itching ❑sneezing ❑congestion (worse in the: ❑AM ❑PM ❑all day) ❑drainage (color_____)
❑postnasal drip ❑snoring ❑runniness ❑sleep apnea ❑blood ❑decreased smell

throat: ❑soreness ❑redness ❑itching ❑mucus ❑throat clearing ❑hoarseness ❑bad breath

Resp: ❑cough (worse in the: ❑AM ❑PM ❑all day, ❑cough wakes patient up at night (# of times waking up_____),
cough is: ❑dry ❑moist (color of discharge_____) ❑cough is worse with exercise,
❑cough is worse with laughter, ❑cough is worse with crying, ❑cough is worse: ❑lying down ❑upright)
❑wheezing year of last chest X-ray_____ results of last chest X-ray_____

CV: ❑tightness in the chest ❑shortness of breath ❑chest pain (location_____)

tobacco: ❑cigarettes (number of packs per day_____ years smoked_____ year quit_____) ❑cigars ❑pipes
❑smokers in the home presently/previously (who_____) ❑smokeless tobacco (chew)
❑electronic cigarette (vapor)

GI tract: ❑heartburn/stomach reflux: worse in the: ❑AM ❑PM ❑after meals ❑all day, ❑heartburn/reflux makes the cough worse
❑hiatal hernia ❑nausea ❑vomiting ❑diarrhea ❑constipation ❑pain (frequency_____)

Const: ❑headache: ❑dull ❑throbbing ❑pressure (❑forehead ❑cheeks ❑between the eyes ❑behind the eyes)
❑temples ❑"band-like" around head ❑back of the head ❑migraines frequency of headaches_____
❑fatigue ❑irritability ❑dizziness ❑night sweats ❑fevers ❑sleeps poorly at night (# of times waking up per night_____)

Skin: ❑eczema ❑rash ❑hives ❑swelling ❑itching ❑dry skin (location_____)

All/Imm: insect reactions to: ❑bees ❑wasps ❑hornets ❑fire ants ❑mosquitoes ❑chiggers
with reactions, was there associated: ❑large local swelling ❑hives ❑wheezing ❑throat swelling ❑nausea/diarrhea
❑unconsciousness ❑emergency treatment required age at time of reaction_____
❑facial rash ❑mouth ulcers ❑easy bruisability ❑dry eyes ❑severe sun sensitivity

Mus/Skel: ❑joint pain ❑joint swelling ❑muscle pains ❑muscle weakness ❑muscle wasting ❑leg swelling

Endo: ❑unintentional weight loss ❑weight gain ❑hot flashes ❑goiter ❑excessive hair loss
❑nursing ❑pregnant ❑planning pregnancy; when_____

Gen/Urin: ❑blood in the urine ❑foamy urine ❑painful urination ❑incontinence ❑bedwetting
(all others negative)

 Reviewed_____

Patient Name: _____ **DOB** _____

Past Medical History: **(If patient is a child, please complete birth information below)**

birth weight_____lbs. _____oz. ❑pregnancy complications ❑delivery complications

❑vaginal delivery ❑C-section ❑premature ❑full term

❑breast fed (how long?_____) ❑formula fed (❑milk ❑soy) ❑colic ❑feeding problems

❑recurring infections (❑ear ❑sinus ❑tonsil ❑throat ❑chest ❑skin)

❑school problems_____

(All patients should answer the following questions):

immunizations: ❑unknown ❑DTP (year of last tetanus immunization_____) ❑IPV (polio) ❑MMR (mumps measles rubella)

❑HIB (Haemophilus influenza B) ❑hepatitis vaccine ❑HPV

❑ Pneumovax 23 (year _____) ❑ Prevnar 20 (year _____) ❑Prevnar 13 (year _____)

❑flu vaccine (year of last shot_____) ❑reactions:_____

❑ Covid-19 Vaccine Manufacturer _____ Date (s): _____

Medical History: **Surgical History:** **Present Medications:** (including over-the-counter and supplement medications)

list major illnesses or diseases	year	procedure	list names of medications	dosage	# times per day
1)	1)_____	tonsillectomy & adenoidectomy	1)		
2)	2)		2)		
3)	3)		3)		
4)	4)		4)		
5)	5)		5)		
6)	6)		6)		

Please list any recent **antibiotics** prescribed in the past year (for respiratory issues)

list names of medications	dates	dosage	# times per day
1)			
2)			
3)			

7) Covid-19 Vaccine Dose 1

8)

9)

hospitalizations:

Family History: marital status: (marital status of the parent if the patient is under 18) M S D W Sep

If patient is an adult:

	age	name
Patient's children: 1)		
2)		
3)		
4)		
5)		

For all patients:

	age	name
Please list patient's brothers and/or sisters: 1)		
2)		
3)		
4)		
5)		

check illnesses present in immediate family members (blood relatives) ☑:

❑asthma ❑hay fever or nasal allergy ❑eczema ❑hives ❑food allergy ❑insect allergy ❑medication allergy

List Family Member: _____

(Draw arrows to family members with illnesses checked.)

❑lung disease ❑heart disease ❑diabetes ❑cancer (type:_____) ❑immune disorder

❑other _____

 Reviewed_____

Patient Name: _____ **DOB** _____

Environmental History:

home: ❑townhouse ❑apt ❑house (age_____yrs, occupied by patient_____yrs) ❑city/suburb ❑country/farm
❑basement is: ❑dry ❑damp ❑musty ❑poured concrete ❑rock/stone ❑concrete block
❑basement is finished ❑dehumidifier is used in basement ❑crawl space ❑slab

windows: windows open during the ❑spring ❑summer ❑fall ❑never

attic fan: the attic fan is used in the: ❑spring ❑summer ❑fall ❑never used ❑attic fan use makes symptoms **worse**

heating: ❑natural gas (❑forced air) ❑electric ❑wood ❑LP gas ❑oil

humidifier: ❑attached on furnace ❑free-standing (location_____)

air conditioning: ❑central ❑window units (❑window unit in patient's bedroom) ❑air conditioning makes symptoms **better**

air filter: ❑disposable (how often is it changed?_____) ❑HEPA filter ❑electronic ❑electrostatic

bedroom: location (❑above ground ❑basement) ❑wall-to-wall carpeting ❑hardwood floor ❑area rug

pillow: ❑feather ❑synthetic/foam (**number of pillows**_____, **how old**_____yrs) ❑**special** allergy proof covers over pillows
spouse's pillow: ❑feather ❑synthetic/foam (number of pillows_____, how old_____yrs.)

mattress: ❑inner spring mattress (**age of mattress?**_____yrs) ❑foam Tempurpedic (**age of mattress?**_____yrs)
❑sleep number bed ❑**special** allergy proof cover over mattress (zippered type) ❑plastic cover on mattress ❑futon

mattress pad: what temperature water is the mattress pad washed in?: ❑hot ❑warm ❑cold)
❑cotton (washed how often_____ ❑feather mattress pad ❑egg-crate mattress pad

sheets: washed how often_____, what temperature water are the sheets washed in?: ❑hot ❑warm ❑cold

bed cover: ❑comforter (❑feather fill ❑synthetic/fiber fill ❑cotton) ❑blanket ❑quilt ❑bedspread

pets: ❑cats (number_____ ❑indoor ❑outdoor), ❑dogs (number_____ ❑indoor ❑outdoor), ❑other pets_____
Where do the pets sleep at night? _____ Do the pets get ❑ into bedroom ❑on bed

Diet: How many days per week, do you/patient eat: ❑chocolate ___/ 7 days ❑peppermint ___/ 7 days ❑fatty foods ___/ 7 days ❑spicy foods ___/ 7 days
❑tomato products ___/ 7 days ❑citrus juice___/ 7 days?
❑Do you/patient eat 2-3 hours before bed? ❑ drink water or fluid 30 min before bed? **If so, how much?**___**oz.** ❑water at bedside?

Social History:

alcohol: ❑beer ❑wine ❑liquor (drinks per week_____) tobacco: see HPI illicit drug use: _____

caffeine: ❑tea (cups per day___❑caf ❑decaf) ❑coffee (cups per day___ ❑caf ❑decaf) ❑soda (# per day___ ❑caf ❑caffeine free)
❑energy drinks (# per day___)

Occupation (***or*** school & grade if a student): patient_____ spouse_____
(**if infant/child:** mother's occupation_____ father's occupation_____)
daycare/preschool: where_____ daycare hours_____ number of children present_____

hobbies/crafts: _____

Clinical Disagreements: (Please check the items that make you/the patient's symptoms worse☑)

Nasal/sinus symptoms are ***worsened*** by: ❑smoke ❑aerosols ❑dust ❑perfumes ❑basements ❑cats ❑dogs ❑cold air ❑wind
❑beer ❑wine(❑red ❑white) ❑rain ❑humidity ❑temperature changes ❑season changes ❑weather changes ❑other_____

Lung symptoms are ***worsened*** by: ❑smoke ❑aerosols ❑dust ❑perfumes ❑basements ❑cats ❑dogs ❑cold air ❑wind
❑beer ❑wine(❑red ❑white) ❑rain ❑humidity ❑temperature changes ❑season changes ❑weather changes
❑exercise ❑respiratory infections ❑laughing ❑crying ❑aspirin products ❑salad bars ❑heartburn/reflux ❑other_____

Skin symptoms are ***worsened*** by: ❑poison ivy/oak/sumac ❑cut grass ❑leaves ❑plants ❑cosmetics
❑soaps ❑wool ❑others_____

List food and reaction(s):_____

Patient Name: _____ **DOB** _____

Drug Disagreements or Reactions: (Please list **all** reactions.)

	Year	Medication	Reaction
1)			
2)			
3)			
4)			
5)			
6)			

Please list brand names of products the patient uses:

soap_____ shampoo_____ conditioner_____

detergent_____ dryer sheets / fabric softener_____ toothpaste_____

hairspray_____ cosmetics_____

hair gel_____ perfumes or colognes _____ moisturizer_____

Skin History: (Fill out only if experiencing skin problems)

Hives *and/or* rash and/or swelling/angioedema:

features: date of onset _____ worse in: ❑AM ❑PM ❑all day ❑after meals
❑itching present affected areas: ❑arms ❑hands ❑legs ❑feet ❑stomach ❑back ❑head/face
appearance: ❑red ❑flat ❑raised ❑blistery ❑leaves marks/bruises ❑hives/rash move around
❑hives/rash stay in one spot how long do the hives/rash last?_____
hives or rash is described as ❑mild ❑moderate ❑severe

triggers: ❑heat ❑exercise ❑sunlight ❑cold ❑water ❑pressure ❑vibration ❑rubbing/scratching
❑contact (what material/plant/food/animal/cosmetic? _____)
❑menstrual cycle/hormones ❑stress ❑food (which ones?_____)
❑infections/colds/flu ❑medication (which one? _____)

symptoms: ❑recent cold or flu ❑joint pains ❑joint swelling ❑sun sensitivity ❑facial rash ❑fever ❑foamy urine
❑blood in the urine ❑hair loss ❑abdominal pain ❑fatigue ❑mouth sores ❑facial/sinus pain or pressure
❑nasal congestion ❑postnasal drip ❑sinus pressure/headache ❑tooth pain
❑weight gain ❑weight loss ❑goiter ❑diarrhea ❑shakiness ❑hot flashes

new medications (prescription or over-the-counter)_____

_____

new foods_____