Patient Information:

Name: ______________________________ Date of Birth: ____________________ Age: ____

Social Security Number: _________________________________ Gender: Male Female

Primary Care Physician: _______________________ Referring Physician: ____________________

If not referred by a physician, how did you hear about us? ________________________________

Family members who are patients here? ____

E-mail Address : ____

Mailing Address: ____

City: __________________________________ State: _______ Zip Code: _____________________

Phone:(Primary) ___________________________ (Secondary) ____________________________

Emergency Contact Information:

Name: _________________________________ Relationship to patient: ______________________

Address (if different from patient) ____

Phone: __________________________________

If Applicable:

Marital Status: (please circle) Single Married Divorced Widowed

Patient Employer: ______________________________ Occupation: _________________________

Guarantor Information: (Please fill this section out with Guarantor's information)

Policy Holder's Full Name: _________________________________ Date of Birth: ___________

Relationship to Patient: SELF PARENT SPOUSE OTHER: _________________

Policy Holder's Social Security #: ____

Mailing Address if different from Patient: ____

City: ___________________________________ State: ________ Zip: ____________________

Primary Insurance Company Name: ____

ID/Policy #: ____________________________________ Group# :________________________

Secondary Insurance Company Name: ____

ID/Policy #: ____________________________________ Group #: ________________________

Payment is expected at time of service for any amounts known to be not covered, or not paid by your insurance plan, including all copays and coinsurance amounts. We accept cash, personal checks, and credit/debit cards (Visa, Mastercard, Discover, AMEX, and most FLEX/HAS spending cards. A fee of $35 will be charged for all returned personal checks.

If your insurance company does not respond within 30 days after your claim is filed, payment will become your responsibility. Any amount remaining after insurance has paid or denies will be expected to be paid upon receipt of your statement unless other arrangements are made with our billing department.

It is your responsibility to notify us of any changes to your insurance. If you do not, you will be fully responsible for any amount rejected by the insurance company.

We are committed to providing our patients quality care. By informing you of our expectations, we hope to alleviate any misunderstandings concerning your financial responsibility. Should you have any questions about your account, please contact the office at (678) 971-5005 and ask for our billing department.

I authorize release of any information necessary to process claims and direct payment to Advanced Allergy of North GA. I understand that I am responsible for all charges, regardless of insurance coverage. If the patient is a minor, the financial responsibility lies with the parent or guardian bringing the child for treatment.

______________________________________ ____________________________________

Guarantor Signature Date

New Patient Information

Name: ________________________ Regular Physician: ___________________Age: ________

Briefly describe the main reason for your visit today:

____

____

Who can we thank for referring you to our office? _____________________________________

Allergy History:

Circle the following symptoms that you have or have had related to this problem.

Nasal congestion	*Bouts of sneezing*	*Runny nose*
Post nasal drip	*Nasal itching/rubbing*	*Bad breath*
Red eyes	*Itchy eyes*	*Frequent nosebleeds*
Sinus infections	*Discolored drainage*	*Popping in ears*
Bad taste in mouth	*Loss of smell*	*Headaches*

Please Circle things that make your symptoms worse:

Household dust Feathers Animal dander Mold Mildew Damp areas

Tree pollen Grass Leaves Hay Colognes or perfumes Smoke Sun

ExerciseFatigue Change in temperature or humidity Weather changes

Temperature changes Time of day (AM/PM) Workplace Changes in season

Respiratory History:

Circle the following symptoms that you have or have had related to this problem.

Cough Shortness of breath Chest tightness

Cough from post nasal drip Wheezing Symptoms with exercise

Waking up at night with symptoms Frequent oral steroids Frequent inhalers

*Diagnosed with asthma? When?*________________

Gastrointestinal History:

Circle the following symptoms that you have or have had related to this problem.

Vomiting Diarrhea Abdominal pain

Heartburn Regurgitation Ulcer

Skin History:

Circle the following symptoms that you have or have had related to this problem.

Hives	*Swelling*	*Itching*
Eczema	*Rash*	*Dry skin*

Environmental History:

How long have you lived in your current home? _________________

Type of home: house / apartment / mobile home that is __________ years old.

Type of mattress: foam / innerspring / water bed. It is ___________ years old.

Type of pillow: foam / feather / synthetic It is __________ years old.

Floors are mostly carpet / wood / linoleum / other

House is generally dry / dusty / moist / musty

Air conditioning is central / window units / not installed

Heating system electric / gas / oil / wood / kerosene

Change heat/air system filter every __________ months.

Any pets? Yes / No Types: ___________________________ Indoors? Yes / No

Any smokers in the home? Yes / No Who? ________________ Indoors? Yes / No

How many people in the household? ______________________

Anything unusual or remarkable about this home? ___________________________

Please list all of your current medications here. (Include vitamins, supplements, herbs, etc):

___________________________________ ____

___________________________________ ____

___________________________________ ____

Reaction History:

Any reactions to foods? ____

Any reactions to any medications: ____

When did this occur? ____

What was the reaction?:____

Any reaction to insect sting and how it was treated: ______________________________________

____

Past Medical History:

Have you ever been seen by an allergist? Yes / No Who? ________________ When? __________

Have you ever been on allergy shots? Yes / No When? ____________ How long? _____________

Have you ever been seen by an ENT? Yes / No Who? ___________________ When? __________

Any chronic health problems or diagnoses? ____

____

Family Health History:

List any allergic symptoms or asthma in family members (hay fever, asthma, sinus problems):

____

____

Any family members that are patients here? ____
Relationship to patient: ____

Social History:

Occupation? ______________________________ Student? Yes / No

Briefly describe your work/school environment: ____

Tobacco use? Yes / No How long? ________________________

Hobbies? ____