PATIENT INFORMATION

FORT WAYNE Allergy & Asthma CONSULTANTS, INC

TODAY'S DATE: _____ Phone: 260-436-5670

LAST NAME:	FIRST NAME:	M.I.	BIRTH DATE	SEX

IF PATIENT IS A MINOR, LIVES WITH:	RELATIONSHIP

MARITAL STATUS OF PATIENT (Select One) ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated	SSN OF PATIENT

STREET ADDRESS	PRIMARY PHONE NUMBER

CITY	STATE	ZIP CODE	ALTERNATE PHONE NUMBER

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE NUMBER	EMAIL

PATIENT'S EMPLOYER	OCCUPATION	WORK PHONE NUMBER

PATIENT'S EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST WITH THIS FORM

PRIMARY INSURANCE COMPANY	EFFECTIVE DATE	POLICY HOLDER'S NAME	POLICY HOLDER'S SSN	POLICY HOLDER'S DOB

ID #	GROUP #	EMPLOYER'S NAME	TO HOLDER, PATIENT IS: ☐ Self ☐ Child ☐ Spouse ☐ Other

INSURED PARTY'S ADDRESS

SECONDARY INSURANCE COMPANY	EFFECTIVE DATE	POLICY HOLDER'S NAME	POLICY HOLDER'S SSN	POLICY HOLDER'S DOB

ID #	GROUP #	EMPLOYER'S NAME	TO HOLDER, PATIENT IS: ☐ Self ☐ Child ☐ Spouse ☐ Other

INSURED PARTY'S ADDRESS

ANY IMMEDIATE FAMILY MEMBER A PATIENT AT THIS OFFICE?

RESPONSIBLE PARTY (Select One) ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ GUARDIAN ☐ SELF

LAST NAME	FIRST NAME	M.I.	PHONE	BIRTHDATE

ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER'S NAME	PHONE NUMBER	SSN

EMPLOYERS ADDRESS	CITY	STATE	ZIP CODE

PRIMARY CARE PHYSICIAN	CITY

REFERRING PHYSICIAN	CITY

PATIENT INFORMATION

FORT WAYNE Allergy & Asthma CONSULTANTS, INC

PLEASE SIGN ALL THREE AREAS BELOW

CONSENT TO TREATMENT

I hereby voluntarily consent and authorize Fort Wayne Allergy and Asthma Consultants, Inc., through its providers, to perform diagnostic procedures and medical treatment as deemed necessary by the provider. I acknowledge that no guarantees have been made to me as to the result of this treatment. This authorization shall remain in effect indefinitely, unless specifically amended by the patient or legal guardian.

Date	Signature of Patient or Legal Guardian	Date	Signature of Other Parent or Legal Guardian
_____	_____	_____	_____

AUTHORIZATION TO RELEASE INFORMATION AND AGREEMENT TO PAY

I hereby voluntarily consent and authorize Fort Wayne Allergy and Asthma Consultants, Inc., to release any information acquired in the course of the patient's examination or treatment to process insurance claims. In consideration of services rendered and to be rendered by Fort Wayne Allergy and Asthma Consultants, Inc., I agree to pay for all services performed and ordered by the attending provider. I also agree to pay reasonable attorney fees and legal expenses, as permitted by applicable law, incurred in connection with this account. This authorization shall remain in effect indefinitely unless specifically amended by the patient or legal guardian.

Date	Signature of Patient or Legal Guardian	Date	Signature of Other Parent or Legal Guardian
_____	_____	_____	_____

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby assign to Fort Wayne Allergy and Asthma Consultants, Inc., benefits which are due or are to become due to me as a result of medical services for the said patient. I hereby authorize the payments to be made directly to Fort Wayne Allergy and Asthma Consultants, Inc. I understand that I am financially responsible for any portion of the charges for medical services, which for any reason, are not paid by my Insurance Company. I hereby give permission to Fort Wayne Allergy and Consultants, Inc. to contact my insurance carrier to facilitate the process of my claim. This authorization shall remain in effect indefinitely unless specifically amended by the patient or legal guardian.

Date	Signature of Patient or Legal Guardian	Date	Signature of Other Parent or Legal Guardian
_____	_____	_____	_____

GENERAL HEALTH QUESTIONNAIRE

FORT WAYNE Allergy & Asthma CONSULTANTS, INC

Patient Name: _____ Patient DOB: _____

Have you ever had any medical conditions?

Thyroid Disorder	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Type of Cancer: _____		
Heart Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
GERD (Acid Reflux)	☐ Yes	☐ No

Other **MAJOR** medical conditions:

_____

_____

_____

_____

List any major surgeries:

_____

_____

_____

_____

List all current medications:

_____

_____

_____

_____

_____

_____

_____

_____

Have you used tobacco regularly?

☐ Yes ☐ No

If yes, list below:

Age Started: _____

Duration (in years): _____

Average Amount/Day: _____

Do you still use? ☐ Yes ☐ No

Are there any animals in the house?

☐ Yes ☐ No

If yes, list below:

_____

_____

Are you allergic to any medications?

☐ Yes ☐ No

If yes, list below:

_____

_____

_____

_____

_____

Family history of allergies or asthma:

☐ Yes ☐ No

If yes, indicate below:

Mother:	☐ Yes	☐ No
Father:	☐ Yes	☐ No
Sibling(s):	☐ Yes	☐ No

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

FORT WAYNE Allergy & Asthma CONSULTANTS, INC

Acknowledgement of Receipt of Notice of Privacy Practices

I have received Fort Wayne Allergy and Asthma Consultants' Notice of Privacy Practices and understand that my protected health information may be used by this practice as described in the notice.

Patient Name: _____

Patient Date of Birth: _____

I hereby authorize Fort Wayne Allergy and Asthma Consultants, Inc. to disclose my protected health information to (List anyone, other than physicians, hospitals, legal guardians):

_____

_____

_____

_____

_____

This authorization shall remain in effect indefinitely unless specifically amended by the patient or legal guardian.

Please print your name here: _____

Signed (patient or legal guardian): _____

Today's Date: _____

APPOINTMENT CANCELLATION POLICY

FORT WAYNE Allergy & Asthma CONSULTANTS, INC

Cancellation/Reschedule/No Show Policy for Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel or reschedule an appointment, you may be preventing another patient from getting much needed treatment.

If an appointment is not cancelled/rescheduled at least 24 hours in advance, we will charge a one hundred-dollar ($100) fee for a NEW PATIENT appointment and a fifty-dollar ($50) fee for an ESTABLISHED patient appointment. This will not be covered by your insurance company.

Please print your name here: _____

Signed (patient or legal guardian): _____

Today's Date: _____