ALLERGY PROFILE

Symptoms of Common Allergies

Patient Name: _____ **Date:** _____

PLEASE PLACE A ✓ BESIDE THE PROBLEMS YOU ARE EXPERIENCING

☐ SNEEZING	☐ WATERY EYES	☐ THROAT DRAINAGE	☐ THROAT TICKLE
☐ RUNNY NOSE	☐ SWOLLEN LIDS	☐ BLOCKED EARS	☐ WHEEZING
☐ BLOCKED NOSE	☐ ITCHY EYES	☐ ITCHY EARS	☐ TIGHTNESS IN CHEST
☐ LOSS OF SMELL	☐ SORE THROAT	☐ EAR INFECTION	☐ SHORTNESS OF BREATH
☐ HEADACHE	☐ ITCHY MOUTH	☐ COUGH	

Caused by: _____

☐ SKIN ITCH	☐ SWELLING OF LIPS	☐ NAUSEA	☐ IRRITABILITY
☐ RASH	☐ ITCHY HANDS OR FEET	☐ DIARRHEA	
☐ HIVES OR WELTS	☐ STOMACH PAINS	☐ FATIGUE	

1. **When did symptoms start?** _____

2. **What is the worst time of the year?**	☐ Spring	☐ Summer	☐ Fall	☐ Winter
3. **What is the best time of the year?**	☐ Spring	☐ Summer	☐ Fall	☐ Winter
4. **What triggers your symptoms?**	☐ Weather	☐ Exertion	☐ Infection	

Present Medications: _____

Previous treatment: ☐ Allergy Testing ☐ Allergy Shots ☐ Other Medications

Are you allergic to any of the following:

☐ ANIMALS	☐ FOODS	☐ INSECTS
☐ DUST	☐ MEDICINES	☐ SMOKE

What medications are you allergic to? _____

Family History:

Does anyone in your family have allergies? ☐ YES ☐ NO ☐ Unkown (If yes, check below)

☐ FATHER ☐ MOTHER ☐ BROTHER ☐ SISTER ☐ CHILDREN

Is anyone in your family a patient here? ☐ YES ☐ NO

Home Environment:

Your house is ☐ OLD ☐ NEW

Does your home have:

☐ CARPET ☐ AIR CONDITIONING ☐ PLANTS ☐ PETS ☐ SMOKER IN HOUSE

Additional Comments? _____

Pramila K. Daftary, M.D.

3115 Pine Ave., Suite 1008

Waco, Texas 76708

Date: _____

Patient No: _____

PATIENT INFORMATION

Patient's Name	Marital Status M D S W	Date of Birth	Sex	Social Security No.	Driver's License #

Street Address	City & State	Zip Code	Home Phone	Cell Phone

Spouse's Name	Date of Birth	Social Security No.

In Case of Emergency Contact	Relationship to Patient	Phone No.

Primary Care Physician	Address	Phone No.

Referred by: YELLOW PAGES RELATIVE FRIEND

Dr. _____ Address _____ Phone No. _____

EMPLOYER INFORMATION

Patient's Employer	Occupation	Business Phone No.

Address	City & State	Zip Code

Spouse's Employer	Occupation	Business Phone No.

Address	City & State	Zip Code

IF THE PATIENT IS A MINOR OR STUDENT

Mother's Name	Address, City, State, & Zip Code	Home Phone No.	Cell Phone #

Mother's Employer	Social Security No.	Driver's License #	DOB	Business Phone

Father's Name	Address, City, State, & Zip Code	Home Phone No.	Cell Phone #

Father's Employer	Social Security No.	Driver's License #	DOB	Business Phone

INSURANCE INFORMATION

Company	Insured Person

OTHER INSURANCE (IF APPLICABLE)

Company	Insured Person

RESPONSIBLE PARTY (IF OTHER THEAN PATIENT)

Name	Social Security No.	Driver's License No.	Phone No.

Address	City, State, & Zip Code	Relationship to the Patient

Employer	Phone No.

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Private insurance and any other health/medical plan, to issue payment checks(s) directly to Allergy & Asthma Care of Waco for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Allergy & Asthma Care of Waco to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Allergy & Asthma Care of Waco on behalf of myself, and/or my dependents, and understand that making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid at the original.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date

Welcome!

We are very pleased you have chosen Dr. Pramila K. Daftary and the staff of Allergy & Asthma Care of Waco to provide gentle solutions for your allergy and asthma needs. We specialize in complete diagnosis, relief and prevention for adults and children. We are dedicated to establishing a pleasant and professional environment for each of our patients.

The following is a list of very important items to be completed <u>prior</u> to your visit.

1. *Notify our office of your insurance coverage.*
2. *Be certain your Primary Care doctor has obtained a referral.*
3. *Stop taking all over-the-counter antihistamines at least 24 hours before your appointment.*
4. *If your are taking a prescription antihistamine follow the table below.*

ANTIHISTAMINE	STOP TAKING # OF DAYS PRIOR TO VISIT
CLARATIN	10 DAYS
ZYRTEC	3-5 DAYS
ALLEGRA	3-5 DAYS
ATARAX	3 DAYS

(If you are uncertain about what antihistamine you are taking, call our office in advance.

***DO NOT** Stop taking any Asthma Medications.)*

Our policy is to collect payment at the <u>time of service</u>, including all co-pay, deductibles and coinsurance. Attached you will find your benefits as quoted by your insurance company. If you are uncertain what your cost will be, please contact our office and/or your insurance company.

Failure to provide **<u>all</u>** of the required information listed above may result in rescheduling your appointment. Please complete the enclosed forms and bring them to your appointment.

In addition, we realize your time is valuable, please be prepared to be in our office for 2–$2^1/_2$ hours. We have reserved this time especially for you. If you need to reschedule or cancel your appointment, please call 24 hours in advance to cancel or reschedule your appointment at 254-753-3646, if you fail to call you will be charged a **<u>$50.00 NO SHOW FEE.</u>**

Please feel free to call our office if you have any questions about your visit.

REMEMBER TO BRING YOUR COMPLETED FORMS, INSURANCE CARD AND REFERRAL WITH YOU

WE LOOK FORWARD TO YOUR VISIT!

ALLERGY & ASTHMA CARE OF WACO

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manager (check all that apply):

☐ Home Telephone _____
☐ O.K. to leave a message with detailed information
☐ Leave message with call-back number only

☐ Work Telephone _____
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

☐ Written communication
☐ O.K. to mail to my home address
☐ O.K. to mail to my work/office address
☐ O.K. to fax to this number

☐ Other (spouse, child, etc.)_____
_____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birthdate