CHARLOTTESVILLE CARE

Allergy and Respiratory Enterprises

www.cvilleallergy.com

434-295-ASAP (2727)

Specialized Medicine. Personalized Care.

- PATIENT FORMS -

Patient Name: _____ DOB: _____

Date of Appointment: _____ Insurance Carrier: _____ Initials: ____

Who may we thank for referring you to our office? _____

Briefly describe the reason for your visit today and what you hope to accomplish:

_____

_____

_____

1. Symptoms: Have you ever had any of the following?

	How many days in the last month?	Mild	Moderate	Severe	Circle the months most severe
Runny or stuffy nose					J F M A M J J A S O N D
Itchy Nose					J F M A M J J A S O N D
Sneezing					J F M A M J J A S O N D
Wheezing					J F M A M J J A S O N D
Coughing					J F M A M J J A S O N D
Skin Problems					J F M A M J J A S O N D

2. Medical Problems: Have you EVER had any of the following? **Please Circle**

Allergies	Hernia	Emphysema
COPD	Stroke	High Blood Pressure
Diabetes	Migraine	IBS
Contact Dermatitis	Asthma	Gastritis
Autoimmune Disease	Heart Attack	Acid Reflux
Allergic Conjunctivitis	Ulcer	Prostate Problems
Pneumonia	Epilepsy	Arthritis
Thyroid Disease	Cancer	Other:

3. Surgeries/Hospitalizations:

List Most Recent First Reason Date

a) _____

b) _____

c) _____

d) _____

e) _____

4. Medications:

a) List ANY medication or nasal sprays that you have tried for your allergy symptoms:

_____

b) Please list ALL medications that you take daily (include eye drops, creams and vitamins) :

_____

_____

_____

_____

_____

c) What pharmacy would you like us to use for any prescriptions that you may need?

_____

d) Are you allergic to ANY medications? _____ If yes, what are they and what happens when you take those medications? _____

_____

5. Have you ever had an allergic reaction to ANY food? _____ If yes, what are they and what happens when you eat them? _____

_____

6. Are you allergic to bees or any other stinging insect? _____ If yes, which insects and what reactions do you have? _____

_____

7. Family History (including parents, siblings and grandparents):

Does anyone in your family have allergies or sinus problems? _____
If yes, who? _____
Does anyone in your family have skin problems or eczema? _____
If yes, who? _____
Does anyone in your family have asthma? _____
If yes, who? _____
Does anyone in your family have an Autoimmune Disease? _____
If yes, who? _____
Does anyone in your family have Emphysema or lung disease? _____
If so, who? _____

8. Social History:

Do you drink alcohol? _____ How often? _____ How much? _____
Do you use illegal drugs? _____ If yes, what? _____
Who lives in your home with you? _____
Do you have a living will? _____ Do you have a power of attorney? _____

9. Smoking History:

Do you currently smoke? _____ How many packs per day? _____
If you do not currently smoke, have you EVER smoked?_____
How long has it been since you quit? _____
Do you currently use any other forms of tobacco (chew, snuff, etc.)? _____
Does anyone that lives in your home smoke inside? _____

10. Environmental History:

Do you live in the city or country? _____ House or an apartment? _____
Do you have a basement? _____ Is it damp or dry? _____
Do you run a humidifier in your home? _____ Do you run a dehumidifier? _____
Do you use window units or central air for air conditioning? _____
How do you heat your home (heat pump, wood stove, baseboard heat, etc.)? _____
What type of floors are in your living room (carpet, hardwood, etc.)? _____
What type of floors are in your bedroom? _____
Do you have a waterbed? _____ If not, how old is your mattress? _____
Is your mattress encased with a hypoallergenic covering? _____
What type of pillows do you use (feather, foam, polyester, etc.)? _____
Is your pillow encased with a hypoallergenic covering? _____
Do you have pets? _____ If yes, what kind? _____
Do your pets spend time inside your home? _____

11. Occupational History:
What is your current job? _____
Are you exposed to allergens at work? _____
Have you ever been exposed to allergens at any previous job? _____

12. Immunizations:
Are you up- to- date on all of your immunizations (flu shot, polio, tetanus, etc.? _____
Have you ever had a reaction to an immunization? _____

13. Previous Allergy Evaluation/Therapy:
Have you ever been to another allergy specialist? _____
If so, who? _____ How long ago? _____
What were the results of testing? _____
Did you ever receive allergy shots/tablets? _____

14. Is there anything else that you would like us to know about? _____
_____
_____
_____

DEEMED CONSENT FOR DESIGNATED BLOOD-BORNE PATHOGENS

If a healthcare worker is exposed to your blood or body fluids, testing may be performed on a sample of your blood to determine the presence of Hepatitis B and C, and the Human Immunodeficiency Virus (HIV) which causes acquired immunodeficiency syndrome (AIDS). This notice advises you that the following policy is in effect at this facility, in accordance with the Virginia Acts of Assembly Section 32.1 – 45.1, whenever any healthcare worker associated with or working for Charlottesville Allergy & Respiratory Enterprises (CARE) is directly exposed to blood or body fluids of a patient in a manner which, according to the guidelines of the Centers for Disease Control, may transmit human immune--deficiency virus or Hepatitis B and C: Healthcare providers are required to notify you that this testing will occur upon such exposure. Testing of the patient will be conducted by the patient's personal physician, and testing of the exposed CARE employee will be conducted by the employee's personal physician. The results will be made available to the patient, CARE, and applicable health authorities, and will otherwise be kept confidential. I acknowledge that I have read and I understand this consent, and that I have been given an opportunity to ask questions.

Signature: _____ Date: _____

CHARLOTTESVILLE ALLERGY & RESPIRATORY ENTERPRISES, PLLC

Patient Financial Responsibility

I hereby assign to Charlottesville Allergy & Respiratory Enterprises, PLLC all payments for all services rendered to myself and/or my dependents. I understand that I am responsible for payment of any amount not paid by my insurance company and that billing my insurance company is a courtesy and not an obligation of this office.

I acknowledge than any insurance claims pending beyond thirty (30) days are my responsibility. I will immediately pay the balance if the account balance is more than thirty (30) days past due. I understand that if I make a payment and Charlottesville Allergy & Respiratory Enterprises, PLLC thereafter receives payment from my insurance company, I will be reimbursed. I understand that if my account is still outstanding after sixty (60) days from the date of service(s), my account may be referred to a collection agency or an attorney for collection unless prior agreements are made.

Co-payments are required at the time of service in accordance with your insurance plan obligations. We will submit today's visit to your insurance company.

◈ I agree to pay interest on the total unpaid monthly balance at the rate of 18.00% APR, such interest to begin if the account is thirty (30) days past due and calculated from the date of service.

◈ I agree to pay all cost of collections, including, but not limited to thirty-five percent (35%) collection fees and attorney fees of thirty-three percent (33%), but not less than $200.00, regardless if suit is filed or not, as well as all court costs.

◈ I understand Charlottesville Allergy & Respiratory Enterprises, PLLC **DOES NOT** accept postdated checks.

◈ Broken, missed, or cancelled appointments without 24 hours prior notification will be charged a missed appointment fee of $75.00.

◈ **I will pay any expected deductible and co-insurance amounts today and at each future office visit.**

◈ CARE will gladly complete school forms and other required forms presented at the time of an office visit at NO CHARGE. There will be a $15.00 fee to process any form or request not presented during an office visit.

◈ Parent(s) or legal guardian(s) are required to accompany all minors to their office visits. The parent(s) or legal guardian(s) are responsible for any patient due balances at the time of service.

As a medical practice, we will ask you to complete Health History Forms. We will ask you for updates of your personal and medical information. It is important to us and to your treatment here. Your cooperation in completing this information is appreciated.

THERE WILL BE A FEE OF $35 FOR ALL RETURNED CHECKS.

PRINT NAME (PATIENT) SIGNATURE OF RESPONSIBLE PARTY DATE