The Virginia Center for Allergy & Asthma

Robert A. Sikora, M.D., FACAAI
Darshana Alle, M.D.

NEW PATIENT REGISTRATION FORM

Name: _____ **DOB**:_____
First Middle Last

Address: _____
House Number/Street Name City State Zip

Sex: □ Male □ Female **Marital Status:** □ Single □ Married □ Divorce □ Widowed

Ethnicity: _____ **Race:** _____

Home #: _____ **Work #** _____ **Cell #:** _____++_____

E-mail Address: _____ **Social Security #**: _____

For pediatric patients (< 18 years old):

Parent/Guarantor Name:_____

Address (if different than above):_____

Primary Care Physician/Pediatrician: _____ **Phone #**

Pharmacy Name/Location: _____ **Phone #:**

Emergency Contact: _____ **Relationship**: _____ **Phone #** _____

How were you referred to The Virginia Center for Allergy and Asthma? _____

INSURANCE INFORMATION

** If your insurance is an HMO, please bring your referral. If you do not have your referral, you will have to sign a WAIVER prior to being evaluated.**

PRIMARY INSURANCE INFORMATION

Policy Holder's Name: _____ **DOB**:_____
First Middle Last

Address: _____+_____
House Number/Street Name City State Zip

Name of Insurance: _____**ID #** _____**Group #:** _____

Preferred Phone #:_____ **Relationship to Patient:** _____

Employer: _____**Social Security #**: _____

SECONDARY INSURANCE INFORMATION

Policy Holder's Name: _____ **DOB**:_____
First Middle Last

Address: _____
House Number/Street Name City State Zip

Name of Insurance: _____ **ID #** _____ **Group #:**

Preferred Phone #:_____ **Relationship to Patient:**

Employer: _____ **Social Security #**: _____

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FINANCIAL STATEMENT

INSURANCE

I/The Policyholder hereby authorize The Virginia Center for Allergy and Asthma to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with my regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier (or, in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration.) A copy of the authorization may be used in place of the original. This authorization may be revoked by either myself or my insurance carrier at any time in writing.

The Virginia Center for Allergy and Asthma will make every effort to contact your insurance company to verify your benefits. However, verification of benefits is not a guarantee of payment. If the insurance denies payment or services that are not covered, the Policyholder will become financially responsible for these services.

Patient/Responsible Party Initials: _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to The Virginia Center for Allergy and Asthma for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. I understand and agreed that I am financially responsible for charges not paid by my insurance company.

Patient/Responsible Party Initials: _____

PAYMENT POLICY

I understand that payment for services is due at the time services are rendered. All returned checks are subject to a $25 Return Check Fee. If it becomes necessary to refer my account to an outside collection agency, I agree to pay Collection Fees and/or Attorney Fees. I authorize Virginia Center for Allergy & Asthma and their business partners to call my cell phone for collection of the debt.

Patient/Responsible Party Initials: _____

MISSED APPOINTMENT POLICY

I understand that if I do not give a minimum of 24 hours notice for cancellation of an appointment, I will be charged a $50.00 No-Show Fee that is not covered by the insurance plan.

Patient/Responsible Party Initials: _____

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PRIVACY NOTICE/DISCLOSURE STATEMENT

In general, HIPAA (Health Insurance and Portability and Accountability Act) gives patients the right to request restriction on uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communication or that communication of PHI is made via alternative means, such as sending correspondence to the patient's office instead of the patient's home.

The Privacy Rule generally requires health care providers to take reasonable steps to limit the use or disclosure of and requests fro PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. To assist us with this requirement, our office will only release information with a written request signed by the patient or legal representative of said patient. This includes requests made by other physicians and their offices. Our office will supply the proper form. Note: Uses and disclosures for PHI may be permitted without prior consent in the event of an emergency. All authorizations will be in effect until revoked in writing by the patient or legal representative of the patient.

Contact Preference:

I prefer to be contacted regarding my PHI in the following manner (please check all that apply):

- □ Home Phone # : _____
  - □ Please leave a detailed message.
  - □ Please only leave a message with a callback number.
- □ Cell Phone #: _____
  - □ Please leave a detailed message.
  - □ Please only leave a message with a callback number.
- □ Work Phone #:_____
  - □ Please leave a detailed message.
  - □ Please only leave a message with a callback number.

For children/patients less than 18 years old:

- □ I authorize The Virginia Center for Allergy and Asthma to discuss all pertinent medical information with the parent(s)/legal guardian(s) of the child.
- □ I do NOT authorize The Virginia Center for Allergy and Asthma to discuss all pertinent medical information with the parent(s)/legal guardian(s) of the child.

Disclosure Information:

I authorize The Virginia Center for Allergy and Asthma to disclose or provide any and all protected PHI to:

Name: _____ Phone #: _____

Relationship: _____

Signatures:

_____ _____

Patient/Parent/Legal Guardian Date

_____

Printed Name of Above Signature

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I hereby authorize the physicians of The Virginia Center for Allergy and Asthma to use and disclose my health information which specifically identifies me, or which can reasonably be used to identify me, to carry out my treatment, payment, and health care operations. I understand while this consent is voluntary, if I refuse to sign this consent, the physicians of The Virginia Center for Allergy and Asthma can refuse to treat me.

I have been informed that the physicians of The Virginia Center for Allergy and Asthma have prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have been given the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent by notifying the physicians of The Virginia Center for Allergy and Asthma in writing, but if I revoke my consent, such revocation will not affect any actions the physicians of The Virginia Center for Allergy and Asthma took before receiving my revocation.

I understand that the physicians of The Virginia Center for Allergy and Asthma have reserved the righ to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request the physicians of The Virginia Center for Allergy and Asthma restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health care operations. I understand that the physicians of The Virginia Center for Allergy and Asthma do not have to agree to such restrictions, but that once such restrictions are agreed to, the physicians of The Virginia Center for Allergy and Asthma must adhere to such restrictions.

_____ _____

Signature of Patient/Parent/Representative/Guardian Date

_____

Printed Name of Above Signature

_____

Relationship to Patient

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NEW PATIENT QUESTIONNAIRE

Patient Name: _____ **DOB**: _____ **Age:** _____ **PCP:**_____

REASON FOR TODAY'S VISIT:

_____

CURRENT MEDICATIONS: please list ALL medications you take (include over-the-counter, vitamins, herbals)

Medication	Dose	Frequency

Have you ever had a suspected allergic reaction to any of the following below? If so, please describe below.

Medication(s)/reaction:
Food(s)/reaction:
Insect sting(s)/reaction:
Latex product(s)/reaction:

Do you carry an Epi-Pen? □ No □ Yes

PAST MEDICAL HISTORY Please list any chronic medical conditions you have had (include hypertension, diabetes, acid reflux, thyroid disorder, cancer, etc.)	PAST SURGICAL HISTORY Please list any past surgeries you have had with the approximate date (include tonsils/adenoid removal, sinus surgery, gallbladder removal, C-section, etc.)

FAMILY HISTORY: please check all pertinent conditions for your immediate family members.

Relative	Environmental allergy ("hay fever)	Asthma	Eczema	Food Allergy	Medication Allergy	Hives/Swelling	Other (please list high blood pressure, diabetes, cancer, etc)
Mother							
Father							
Sibling(s)							

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IMMUNIZATION HISTORY:

Have you had the flu shot?	□ Yes □ No □ Not Sure If yes, date received:
Have you had the pneumonia shot? (Pneumovax)?	□ Yes □ No □ Not Sure If yes, date received:

ENVIRONMENTAL HISTORY:

Type of housing/setting	□ House □ Apartment □ Mobile home □ Condominium □ Other Number of years living in this location:_____
Type of flooring in residence	□ Hardwood □ Carpet □ Tile □ Linoleum □ Area rugs □ Other
Pets	□ Yes □ No If yes, please describe type and # of pet(s):
Heating/cooling system	□ Central air/heat □ Window units □ Space heater □ Ceiling Fans □ Other
History of flooding/water leaks?	□ Yes □ No
Visible mold/mildew	□ Yes □ No
Use of dust mite encasings on mattress/pillows	□ Yes □ No

SOCIAL HISTORY:

Tobacco use/exposure	□ Never smoked □ Current daily smoker □ Former smoker □ Current some day smoker (social) □ Unknown if ever smoked **If current/former smoker:** Type: □ cigarettes □ cigars □ chewing □ pipe □ snuff □ smokeless Packs/units per day: _____ Years used: _____ Ever tried to quit? Y/N Year quit: _____
Passive/second hand smoke exposure	□ No □ Yes If yes, where: _____
Alcohol use	□ No □ Yes If yes, how often: □ rarely □ weekly □ daily □ socially
History of illicit drug use/substance use	□ No □ Yes If yes, how often: □ rarely □ weekly □ daily □ socially
Employment Status	□ Current Employed (list occupation:_____) □ Not Employed □ Student □ Retired (list occupation:_____)

PEDIATRIC PATIENTS ONLY

School/daycare attendance	□ Yes □ No Name of school/daycare:_____ If yes, how many days a week: _____
Birth	□ Premature □ Full term □ Vaginal □ C-section
Breastfeeding	□ Yes □ No If yes, for how long:_____
Formula feeding	□ Yes □ No If yes, what formula base is being used? □ Milk □ Soy □ Other
Immunizations up to date	□ Yes □ No