Justin Clark, D.O., F.A.A.A.A.I.
ALL SEASONS ALLERGY & ASTHMA CENTER
Advanced care to help you breathe better... for life.

PATIENT INFORMATION

Patient Last Name: _____ First: _____ Middle Initial _____
Date of Birth: ____/____/____ Age: _____ Social Security: _____/_____/_____
Sex: (please circle) Male/Female Marital Status: (please circle) Single/Married/Divorced/Widowed
Patient Address: _____
Cell Phone #1:_____ Alternate Phone #2:_____
Email address: _____ Enroll in Patient Portal (please circle) Yes/No
Preferred Language: _____
Referring Physician: _____ Primary Physician: _____
Preferred Pharmacy: _____ Address: _____Phone: _____

EMERGENCY CONTACT/ALTERNATE CONTACT INFORMATION

Last Name: _____ First: _____ Relationship to Patient: _____
Cell Phone #1: _____ Alternate Phone #2: _____

RESPONSIBLE PARTY/GUARDIAN/GUARANTOR (if different from patient)

Last Name: _____ First: _____ Middle Initial _____
Relationship to Patient: _____ Social Security: _____/_____/_____
Address: _____ Phone #:_____

PRIMARY INSURANCE INFORMATION

Name of Insurance Co: _____Member/Policy #:_____
Subscriber Name:_____ Date of Birth: __/__/___ Relationship to Patient:_____
Subscriber Social Security: _____/_____/_____ Subscriber Phone_____
Subscriber Address: _____

SECONDARY INSURANCE INFORMATION

Name of Insurance Co: _____Member/Policy #:_____
Subscriber Name:_____ Date of Birth: __/__/___ Relationship to Patient:_____
Subscriber Social Security: _____/_____/_____ Subscriber Phone_____
Subscriber Address: _____

MEDICAL RELEASE

I hereby give permission to disclose, discuss and speak with the individuals listed below regarding the patient's personal health information or treatment. I understand that I can amend this list at any time by submitting a request in writing. I consent to the release of the patient's health information to the following individual(s) (please include parents, co/step-parents, spouse, children, siblings):
Print Name:_____Relationship:_____
Print Name:_____ Relationship:_____
Print Name:_____ Relationship: _____

I hereby authorize my insurance benefits including Medicare to be paid directly to All Seasons Allergy and Asthma Center, P.A. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize All Seasons Allergy and Asthma Center, P.A. to release all information necessary to secure that payment.

Patient/Parent/Guardian Signature: _____ Date: _____
Printed Name:_____
Relationship to Patient: _____

362 Beal Parkway, Suite #105 • Fort Walton Beach, FL 32548
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NEW PATIENT QUESTIONNAIRE

INSTRUCTIONS: Carefully complete all 3 pages of this form in full. Relate all answers to your own experience. Please use black ink pen to complete your responses.

NAME: _____ AGE: _____ DOB: _____ DATE: _____

Referred by: _____ Your primary physician is: _____
Address (if not local): _____

The major problem you wish to discuss is: _____

List medications you have tried in the past for your allergy problem: _____

Are you allergic to any medicines? List drug, type of reaction and year:

I. Symptoms (check all that apply):

Eyes: Itch ☐ Swell ☐ Burn ☐ Tear ☐ Discharge ☐ Dry ☐

Ears: Itch ☐ Fullness ☐ Popping ☐ Hearing ☐ Ringing ☐ Pain ☐

Nose: Sneeze ☐ Itch ☐ Runs ☐ Stuffy ☐ Mouth Breather ☐
Snoring ☐ Yellow/Green Drainage ☐ Poor sense of smell ☐
Headache ☐(which part of head_____ How often_____ How severe_____

Throat: Itch ☐ Sore ☐ Post Nasal Drip ☐ Throat Clearing ☐ Swelling ☐

Chest: Cough ☐ Phlegm ☐ Color and amount _____
Wheezing ☐ Chest Tightness ☐ Shortness of breath with exercise ☐
Nighttime Wheezing/Cough ☐ Asthma diagnosed by a physician ☐

Gastrointestinal: Abdominal pain☐ Nausea☐ Vomiting ☐ Diarrhea ☐

Endocrine: Sensitivity to hot/cold temperatures☐ Frequent urination ☐ Excessive thirst ☐
Excessive hunger ☐

Skin: Eczema ☐ Hives_☐ Swelling ☐ Rash ☐
Where on body? _____

A. Respiratory allergies

1. Age or onset of your hay fever, and/or asthma _____.

2. Do you have daily symptoms? _____

3. Does any particular exposure (e.g. cat, smoke, weather change, work, school) make you worse? (list)
_____

4. Do you get sinus infections (yellow/green nasal drainage, pain, etc.)? _____ How often? _____
How are the sinus infections usually treated? _____

5. What time of year are your allergies worse? (please list months) _____

6. Have you ever been hospitalized for your asthma? _____ Emergency room? _____

7. Have you had nose or sinus surgery? _____

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Patient Name: _____ **Date:** _____
Patient DOB: _____

B. Food allergies
Please list all foods and reaction they cause:

_____

II. Previous Allergy Evaluation and Treatment
A. Name of allergist and city _____

B. Were you tested for allergies by skin test or blood test? _____ When_____ Results_____

_____

C. Have you received allergy shots? _____ When, how long? _____

III. Past Medical History
A. Medical problems: (circle all that apply)

Diabetes	Thyroid problem	High cholesterol	Heart disease	High blood pressure
Prostate	Glaucoma	Stomach ulcer	Hiatal hernia	Abnormal chest x-ray
Depression		Positive Tb Test	Arthritis	Hepatitis
GERD (acid reflux)		Cancer	HIV / AIDS	Other: _____

B. Please list all important operations and other hospitalizations that you have had: _____

C. Have you had a chest x-ray, sinus x-ray, breathing test, blood tests? Comment on results.

_____

IV. Family History

A. Do members of your family have any of the allergy problems mentioned above? (list and comment)

_____

B. Are there any hereditary diseases or other disorders that seem to occur frequently in your family?

_____

V. Personal and Environmental History
A. Do you have any animals at home? (type and for how long) _____

B. Are there any smokers at home? _____ How many? _____

C. **Adults only**: Do you presently smoke? (how much and how long) _____

D. **Adults only**: Have you ever smoked? (how much and how long)_____ Quit: how many years ago _____

E. **Adults only**: What is your occupation?_____
-Are you exposed to any toxic chemicals, noxious substances at work? _____
-Has your problem caused you to miss work? _____

F. **Adults only**: Do you drink alcohol? No ☐ Yes ☐ How much do you drink? _____

G. **Adults only**: Do you use recreational drugs? (this is confidential)

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VI. Review of Symptoms
Do you have any of the following? (check all that apply)

General ____ weight loss ____fevers ____ night sweats ____ loss of appetite ____ dry mouth ____snoring	Kidney ____ trouble starting urine ____ loss of urine with cough/sneeze ____ frequent nighttime urination	Blood ____ anemia (low blood) ____bleed or bruise easily ____ swollen lymph nodes
Cardiovascular ____chest pain ____chest pain with exercise ____calf pain with exercise ____ankle swelling	Musculoskeletal ____ morning joint stiffness and aching ____ painful, swollen joints ____ muscle tenderness or pain ____ muscle weakness	Neurological ____ weakness/clumsiness ____tingling/numbness of extremities
Psychological ____ fearful, anxious ____ excessive worry ____trouble sleeping	Gynecological ____ excess bleeding ____changes in menstrual cycle ____ post-menopausal	

CURRENT MEDICATIONS

Name of Medication	Dosage	Taken for:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		

ALLERGIES TO MEDICATIONS

Name of Medications	Reaction (hives, throat swelling, other reactions)
1.	
2.	
3.	
4.	
5.	

____ **NO KNOWN DRUG ALLERGIES**

Patient/Parent/Guardian Signature: _____ **Date:** _____
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Patient Name: _____ **Date:** _____
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PLEASE INITIAL EACH SECTION BELOW TO INDICATE THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION (PAGE 1 of 2):

_____**CONSENT TO TREAT**

As the patient or the parent, legal guardian, or authorized representative of the patient, I hereby authorize All Seasons Allergy and Asthma Center, P.A. ("All Seasons") to provide medical care and treatment to the patient. I hereby consent to the release of the patient's medical information to doctors, nurses, or other personnel, including but not limited to those in hospitals and other healthcare facilities, who are involved in the patient's medical care and need the information for his/her treatment and to provide treatment-related to healthcare services. All Seasons may use and disclose the patient's medical information for necessary healthcare operations.

Additionally, I consent All Seasons to release all medical information required by the patient's health insurance carrier, Medicare, or any other third-party payer for processing claims for healthcare services provided. I hereby authorize All Seasons to allow contact with the patient's insurance company or health plan administrator to obtain all pertinent financial information concerning coverage and payments under his/her policy and direct said insurance company or health plan administrator to release such information to All Seasons for processing claims for healthcare services provided. I authorize payment from the patient's insurance company or governmental payer to pay directly to All Seasons for services rendered.

_____**FINANCIAL AGREEMENT**

I acknowledge that I am responsible for payment of all charges for healthcare services provided to the patient. Copays, deductibles, charges for services not covered by the patient's insurance plan and outstanding balances are due at the time of the appointment.

To accommodate our patients, we participate and accept many major insurance plans. Each plan has its own restrictions regarding where and how often services may be rendered. It is your responsibility to understand your plan guidelines and inform All Seasons of any special requirements. All Seasons cannot guarantee payment of all claims. If the insurance company pays only a portion of the claim or denies the claim, you will be responsible for payment of all charges for services provided by All Seasons. Some insurance plans require a written referral from a primary care physician for specialist services to be covered. It will be your responsibility to obtain any necessary referrals. If you do not have that referral, you are financially responsible for the services provided to you by All Seasons.

If your account becomes delinquent, All Seasons reserve the right to refer your account to a collection agency and to be reported to the credit bureau. In the event that the account is referred to a collection agency, you agree to pay all costs of collection including reasonable attorneys' fees.

I hereby assign to All Seasons any insurance and other third-party benefits available for healthcare services provided to the patient. I understand that All Seasons has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to All Seasons, you agree to forward to All Seasons all health insurance and other third-party payments that you receive, for said services, immediately upon receipt. Additionally, regardless of my insurance benefits, if any, I understand that I am financially responsible for the costs for services rendered.

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Patient Name: _____ **Date:** _____
Patient DOB: _____

PLEASE INITIAL EACH SECTION BELOW TO INDICATE THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION (PAGE 2 of 2):

_____ **PRIVACY NOTICE**
All Seasons' Notice of Privacy Practices describes how medical information about the patient may be used and disclosed and how the patient can get access to the information. I understand that this notice is posted for my benefit in the reception area and on the website of All Seasons. I acknowledge that I have read a copy of this Notice of Privacy Practices.

_____ **ALLERGY SKIN TESTS**
To determine which specific substances are triggering the your allergies, your allergist will safely and effectively test your skin using tiny amounts of common allergens. These tests are done on the surface of the skin on the back or arm. A tiny amount of allergen is scratched across or lightly pricked into the skin. If you have an allergy, the specific allergens that you are allergic to will cause a chain reaction to begin in your body. With testing, swelling (like a mosquito bite) occurs only in the spots where the tiny amount of allergen to which you are allergic has been scratched onto your skin. Test results are available within 15 minutes of testing, so you do not have to wait long to find out what is triggering your allergies. And you will not have any other symptoms besides the slightly swollen, small hives where the test was done; this goes away within 30 minutes but if very large, they can last up to a day.

Since the allergens are derived from material to which you may be highly allergic, in rare cases you may have a reaction involving your entire body with itching, hives, wheezing, or in severe cases, low blood pressure, swelling of the throat and/or difficulty breathing. Serious reactions may be life-threatening and require close observation. If it does occur, medications to reverse the reaction are readily available and your allergist is always present when the skin testing is performed.

I certify that I understand the information regarding the procedure to be performed upon me or my child, and I have been fully informed of the risks and possible complications.

_____**ELECTRONIC PRESCRIPTIONS**
I consent All Seasons to electronically send prescriptions to the patient's preferred pharmacy.

_____**ELECTRONIC MESSAGING**
All Seasons may use e-mail and SMS text messages for appointment reminders and emergency purposes only. E-mail communications from All Seasons are on an un-encrypted server and the security of such e-mails cannot be guaranteed. Furthermore, All Seasons is not responsible for e-mails reaching any unintended recipients. I will inform All Seasons of any changes of e-mail address or phone number.

Patient/Parent/Guardian Signature: _____ **Date:** _____
Printed Name: _____
Relationship to Patient: _____

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Some medications can interfere with allergy skin testing. Therefore, if you are scheduled to be skin tested for allergies on the day of your appointment, please stop all antihistamines for at least 7 days prior to your appointment. Some common medications containing antihistamines include, but are not limited to, the following:

Advil PM, Advil Allergy, Advil Cold/Sinus
Alavert
Alleve Cold
Allegra
Aller-Cholor
Allermax Caplets
Aller-Med
Astelin (Nasal Spray)
Astepro (Nasal Spray)
Atarax/Vistaril
Azatadine
Banophen
Benadryl
Bromphen
Calm X
Cetirizine
Chlo-amine
Chlor-Trimeton
Clarinex
Claritin
Contac 12 Hour Allergy
Cough Medications with Antihistamine
Cyproheptadine
Deconamine
Dimetapp
Dramamine
Doxepin
Gen-Allerate
Fexofenadine
Loratadine
Nasahist
Nytol
Nyquil
Optimine
Pataday/Patanol
Patanase (Nasal Spray)
Pediacare Allergy
Sominex
Sudafed Cold and Allergy
Tagamet
Theraflu
Triaminic
Tussonex
Tylenol Cold/Sinus/Allergy/Sleep
Unisom
Visine
Xyzal
Zantac
Zyrtec

If you are unsure if your medication contains antihistamines, please feel free to call our office and our staff would be happy to assist you.

Additionally, if you take any blood pressure medication, please do not take any beta-blockers the evening before or the day of your appointment. You may resume the medication after your appointment.

Atenolol (Tenormin)
Atoporal
Coreg (Carvedilol)
Corguard (Nadolol)
Inderal, Inderal LA (Propranolol)
Lopressor
Sotalol
Toprol XL (Metoprolol)

If you have a question about whether it is safe for you to stop your medication, please contact your prescribing physician.

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