FREEDOM ALLERGY
ALLERGY SINUS AND COUGH CENTER

Ruchir Agrawal, MD
115 Genevieve Court, Peachtree City, GA 30269
1255 Johnson Ferry Road, Suite 2A, Marietta, GA 30068

Patient Registration Form

Today's Date:_____

Patient Name:_____ Patient Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email:_____ Gender: male female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Other

Preferred Language: ☐ English ☐ Other

Ethnicity:

☐ Hispanic/Latino ☐ Caucasian ☐ African American ☐ Asian ☐ Prefer not to answer

Employer:_____ Work Phone:_____

Social Security #:_____ Driver's License #:_____

Parent/Guardian Information
(if patient is under 18 years of age)

Parent/Guardian Name:_____ Relation to Patient:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Employer:_____ Work Phone:_____

Social Security #:_____ Driver's License #:_____

Insurance Information

Primary Insurance Company:_____

Address:_____

City:_____ State:_____ Zip:_____

ID Number:_____ Group Number:_____

Guarantor Name:_____ Guarantor DOB:_____

Guarantor Employer:_____

Guarantor Relationship to Patient:_____

Secondary Insurance Company:_____

Address:_____

City:_____ State:_____ Zip:_____

ID Number:_____ Group Number:_____

Guarantor Name:_____ Guarantor DOB:_____

Guarantor Employer:_____

Guarantor Relationship to Patient:_____

Other Information

Pharmacy Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

Primary Doctor Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Doctor Phone:_____ Doctor Fax:_____

Referred by:_____

How did you hear about us? ☐ friend ☐ family ☐ doctor ☐ flyer ☐ community event

☐ internet search ☐ Facebook ☐ www.oit101.org

Financial Policy

I authorize the release of any information necessary to process claims. I request payment of benefits to Freedom Allergy. I understand I am financially responsible for charges not covered by insurance.

If your plan has a co-payment, deductible, and/or co-insurance, you will be expected to pay your portion prior to receiving any service including an office visit and/or immunotherapy. If you are on a high deductible plan, you will be required to pay a minimum of 50% at the time of service until we verify your deductible has been met.

Payment is due at the time of service unless prior financial arrangements have been made with our business office. Any account balance is expected to be paid in full prior to new services being rendered. Should it become necessary for Freedom Allergy to utilize the services of an outside collection agency, you may be held liable for collection agency fees and/or attorney fees.

I understand and agree if care at Freedom Allergy requires a primary care physician referral, it is my responsibility to see that the referral is current prior to receiving care at Freedom Allergy. If no referral is present in advance, I agree to pay for charges at the time of services.

I have read the above Freedom Allergy financial policy and understand my financial responsibility.

Patient/Responsible Party Signature:_____

Date:_____

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HIPAA Acknowledgement and Consent Forms

I. Acknowledgement of Practice's *Notice of Privacy Practices*

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation will not be retroactive.

This Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices as allowed by law.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon execution of this Consent.

This consent was signed by:

_____ _____
Patient's Name (Printed) DOB (mm/dd/yy)

_____ _____
Signed (Patient/Legal Representative) Date

Relationship to Patient (if other than patient):_____

II. Request to Receive Confidential Communications by Alternative Means

As provided by Privacy Rule Section 164.522(b), I hereby give permission for Freedom Allergy to communicate to me about appointments, lab results, and/or patient care by phone messages, texts, email, or fax.

Phone Number:_____

Email Address:_____

Fax:_____

_____ _____

Signed (Patient/Legal Representative) Date

III. Adult Consent to Share Medical Information*

I agree that the Freedom Allergy may disclose certain pieces of my health information to a person of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. I give permission for Freedom Allergy to disclose the following information:

- ☐ Scheduling appointments
- ☐ Lab Results
- ☐ All information regarding assessment, diagnosis, and treatment of my medical condition, including oral immunotherapy, immunotherapy, and other allergic treatments.
- ☐ Other _____

The indicated information may be disclosed either phone or email to:

Name:	Relationship to Patient:	Phone #:	Email:
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____

Patient's Name (Printed) DOB (mm/dd/yy)

_____ _____

Patient's Signature* Date

*Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law.
*Patient can cancel this authorization in writing at any time.

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Patient Intake Form

Today's Date:_____

Patient Name:_____ Patient Date of Birth:_____

Reason for appointment

Please describe in your own words your main reason(s) for seeing us today:

_____

The main problems I have are:

	Eyes		**Ears**		**Nose**
☐	Eye itching	☐	Ear itching	☐	Nose itching (need to rub repeatedly)
☐	Eye redness	☐	Ear ache/pain	☐	Sneezing
☐	Eye watering	☐	Ear ringing	☐	Runny nose / Nasal drainage
☐	Eye swelling/puffy eyes	☐	Ear plugging	☐	Yellow/Green nasal drainage
☐	Eye dryness	☐	Ear discharge	☐	Stuffy nose / Nasal congestion
☐	Need to rub eyes repeatedly	☐	Recurrent ear infections	☐	Nasal polyps
☐	Sensitive to light	☐	Hearing loss	☐	Mouth breather
		☐	Headache	☐	Snoring
				☐	Impaired smell/taste
				☐	Nose bleeds
				☐	Nasal / Sinus Procedures?

	Throat		**Chest**		**Skin**
☐	Constant clearing of throat	☐	Chest tightness or congestion	☐	Hives/whelts
☐	Dry cough	☐	Wheezing	☐	Eczema (red, scaly, itchy skin)
☐	Cough + sputum production	☐	Shortness of breath	☐	Giant swelling of face, eyelids, mouth, lips, tongue, or throat
☐	Throat itchiness	☐	Chest pain	☐	Skin reaction to poison ivy/oak/sumac, metals, chemicals, or cosmetics
☐	Sore throat	☐	Heartburn	☐	Recurrent skin infections
☐	Post nasal drip	☐	Asthma	☐	Rash
☐	Hoarseness			☐	Sensitive to rubber or latex products
☐	Throat swelling				

These symptoms occur or are made worse by:

☐	Spring (March/April/May)	☐	Dampness	☐	Sleep
☐	Summer (June/July/August)	☐	Cold	☐	Emotional upset
☐	Fall/autumn (Sept/Oct/Nov)	☐	Smog	☐	Animals (dogs, cats, birds, etc)
☐	Winter (Dec/Jan/Feb)	☐	Air Conditioning	☐	Irritant fumes/aerosols/sprays
☐	Sudden weather changes			☐	Cosmetics
		☐	Exercise	☐	Odors or scents
☐	Being outdoors	☐	Yardwork		
☐	Being indoors	☐	Dusting or vacuuming	☐	Foods (specify)
☐	Being at work	☐	Tobacco smoke	☐	Other:

List your current medications (including prescription, over-the-counter, vitamins, supplements, etc):

Name	Strength/Dose/Frequency	Start Date

Allergy Medical History

Please identify food, insect, or drug causing a reaction, describe the reaction, and date of reaction:

_____

_____

_____

Have you had previous allergy testing? If yes, please describe:

	Date	Doctor Name	City, State	Skin/Blood Test?	Result(s)
1					
2					
3					

Have you had allergy shots/injections?
☐ yes ☐ no

How long did you do allergy shots?
_____ ☐ still getting allergy shots

Did the injections help you?
☐ yes ☐ no

Did you have any reactions to the shots?
☐ yes ☐ no

If yes, please describe the reaction:

_____

Infection History:

How many “colds,” “flu-like illnesses,” upper respiratory tract infections (sinus/ear/throat infections), or bronchial infections have you had in the past year? _____

How many of the above did you have per year in the past five years? (# /year) _____

What percentage of these infections required antibiotics? _____

Which antibiotics have worked the best for you in the past? _____

Have you had sinus surgery, tonsils/adenoids removed or ear tubes? ☐ yes ☐ no

Asthma History:

Age of onset of hay fever and/or asthma? _____

What time of day or night is the worst for your symptoms? _____

Have you ever been hospitalized for your asthma? ☐ yes ☐ no If yes, date? _____

Have you had previous testing? ☐ pulmonologist function testing ☐ chest x-ray

How often do you need to use albuterol (# times/week? #times /month?)? _____

How many times per year have you been on oral steroids? _____

Home information:

How long have you lived in the South? _____

Do you live in an:
☐ House ☐ Apartment
☐ Mobile Home ☐ Other

Does your home have a basement?
☐ yes ☐ no

History of water damage in your home?
☐ yes ☐ no

How old is your home? _____

Do you smoke, or are there smokers in the home? ☐ yes ☐ no

Kind of pet(s): _____

Are your household pets:
☐ indoor ☐ outdoor
☐ allowed in bedroom

Inside the House:

Heating: ☐ central ☐ electric
☐ gas ☐ wood fireplace

Air Conditioning:
☐ central ☐ in-window ☐ fans

Filter system (HEPA or any other air purifier/filtration system?) ☐ yes ☐ no

Flooring in Main Areas:
☐ carpet ☐ laminate / hardwood / tile

Flooring in Bedroom:
☐ carpet ☐ laminate / hardwood / tile

Allergy encasement on:
☐ mattress/boxspring ☐ pillow

Humidifier? ☐ yes ☐ no

Family History

Do you have history of any of the following in yourself or a family member?

	Self	Mom	Dad	Sibling	Other family
Hay fever/"allergies"	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Hives	☐	☐	☐	☐	
Eczema	☐	☐	☐	☐	
Insect sting allergy	☐	☐	☐	☐	
Chronic sinus issues	☐	☐	☐	☐	
Chronic bronchitis	☐	☐	☐	☐	
Cystic fibrosis	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	
Heart disease	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	
High cholesterol	☐	☐	☐	☐	
Arthritis	☐	☐	☐	☐	
Thyroid disease	☐	☐	☐	☐	
GERD	☐	☐	☐	☐	

Are you currently having any problems with any of the following?

Weight changes, loss of appetite, fever, chills, night sweats?	☐
Changes in skin/hair/nails, rash?	☐
Joint pain/swelling, weakness, stiffness, muscle aches?	☐
Vision loss, double vision, glaucoma, cataracts?	☐
Sinus problems, hearing loss, nasal polyps, ringing in ears?	☐
Headaches, migraines, seizures, memory loss, numbness?	☐
Swollen glands, lumps in the neck?	☐
HIV/AIDS, tuberculosis, other chronic infections?	☐
Blood pressure, heart disease, chest pain, high cholesterol, swelling of legs, strokes?	☐
Wheezing, asthma, shortness of breath, chest tightness?	☐
Diabetes, thyroid deficiency, thyroid excess, autoimmune disease?	☐
Trouble swallowing, nausea, vomiting, diarrhea, heartburn?	☐
Hepatitis and/or liver disease?	☐
Burning or blood in urine, kidney stones, prostate problem?	☐
Blood clots, bleeding disorders, easy bruising, bloody/dark stools, anemia?	☐
Anxiety, depression, mental illness, hallucinations, drug addiction?	☐