ATLANTA ALLERGY & ASTHMA

AAA Physician: ____________________
Referring Physician: ____________________
(Address) ____________________
____

PATIENT MRN#: ____________________
DATE: ____________________

PATIENT INFORMATION

Last Name: ____________ First Name: ____________ Middle Initial: ______
Birth Date: ____________ Sex: ______ Race: ______ Ethnicity: ____________
Billing Address: ____________________
State: ____________ Zip: ______ County: ____________
Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________
Marital Status: ____________ ☐ Student ☐ Veteran ☐ Smoker
Email: ____________ Language: ____________
Ins. Company: ____________ Ins. ID#: ____________ Group #: ____________
Primary Care Dr: ____________________
Address: ____________ Telephone: ____________
____________ State: ______ Zip: ______
Employer (if patient is a minor, this does not apply): ____________________
Telephone: ____________ Occupation: ____________
HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? YES ☐ NO ☐
IF THE ANSWER IS YES, PLEASE GIVE THE PATIENT'S NAME: ____________________

RESPONSIBLE PARTY INFORMATION

If the patient is a minor, the parent with whom the child resides is the responsible party:
Responsible Party: ____________ DOB: ___/___/___
Address: ____________________
State: ____________ Zip: ______ Telephone: ____________
Employer: ____________ Emp Telephone: ____________
Occupation: ____________ Ins. Company: ____________

SPOUSE OR OTHER PARENT INFORMATION

Name: ____________ Occupation: ____________
Employer: ____________ Telephone: ____________

INSURED INFORMATION

Patient's Relationship to Insured (Spouse, Child, Dependent, Other): ____________
If 'Other' Please Specify: ____________________
Name of Insured: ____________ DOB: ___/___/___
Address: ____________ Telephone: ____________
____________ State: ______ Zip: ______

NEW PATIENT INFORMATION

ATLANTA ALLERGY & ASTHMA

Date of Visit: ___________________

Name: ____ Age: _____________ Date of Birth: ___________________

Phone: Home ( ) ___________________________ Phone: Work ( ) ______________________________

Primary Care Doctor: ___________________________ Referring Doctor: ______________________________

Pharmacy: ___________________________ Phone #: ___________________

Briefly describe your main reason for today's visit: ________________________

____

____

How long have you had these problems? ________________________________

How frequently do experience these problems? ____________________________

I. ALLERGY HISTORY

Nasal Symptoms/Causes

1. I have the following symptoms (circle all that apply and star the most troublesome):

nasal congestion	nasal itch/rub	bad breath
fatigue/irritability	red eyes	snoring
post nasal drip	itchy eyes	mouth breathing
runny nose	sinus infections	nosebleeds
sneezing	discolored drainage	loss of taste/smell
nasal polyps	headaches	

2. Circle all symptom triggers (circle all that apply and star the most troublesome):

dust	mold/mildew/	time of day - am/pm
fall pollen	mustiness/dampness	home
springtime pollen	indoors	workplace
cut grass/rake leaves	outdoors	food _______________
dog	weather changes	rain
cat	smoke	
other animals_________	strong odors	
feathers	temperature changes	

Do your symptoms occur year-round or are they seasonal? Circle one or both. If seasonal, list months symptoms occur: ________________________________

3. Have you had sinus x-rays or CT Scan? Yes No

II. RESPIRATORY HISTORY

1. Circle any applicable symptoms.

cough	cough from post nasal drip	wheeze
tightness	symptoms with exercise	shortness of breath

If you circled any of the above symptoms, complete questions 2-7

2. Do you wake up at night because of chest symptoms? Yes No
   times per week/month ______________
3. Did you have problems with your breathing at birth? Yes No
   If yes, explain:
4. Breathing problem is triggered by:

pollen	exercise	colds	sinus infections
mold	heartburn	pets	cold weather
foods	weather change/rain	other ____________________________	

5. Circle any events attributable to your asthma:
   ER visits Hospitalization Intubation ICU admission Pneumonia
6. Have you been on steroids or received a steroid shot for your asthma? Yes No
   If yes, how many times in the past 12 months?_________
7. Have you had a chest x-ray? Yes No Last x-ray: ___________

PROVIDER COMMENTS
(Do not write in this space)

I was asked to see this pt in consultation by

Dr.________________________for

________________________________.

ATLANTA ALLERGY & ASTHMA

III. MEDICATIONS

I take the following medications (include inhalers and nasal sprays):

Name	Dose	Frequency used	
			daily/often/rarely
			daily/often/rarely
			daily/often/rarely

Other medications:

		times a day/week/month
		times a day/week/month
		times a day/week/month
		times a day/week/month

1. Do you use a spacer with your inhaler? Yes No
   If yes, which type? ______
2. Do you own a home nebulizer? Yes No
3. Do you own a peak flow monitor? Yes No
   If so, please list your best peak flow rate ______

IV. PREVIOUS ALLERGY EVALUATION

Have you ever had allergy skin testing? Yes No
If yes, when ______
Were you on allergen immunotherapy (allergy shots/drops)? Yes No
If yes, when ______ Did they help? Yes No

V. ENVIRONMENTAL SURVEY - HOME

General (Circle answers)

1. Where do you live? House Apartment Trailer Condo Other
2. How long have you lived there? ______ Age of Dwelling: ______
3. Pets (If yes, please specify): Yes No
   - Cat indoor outdoor both
   - Dog indoor outdoor both
   - Other indoor outdoor both
4. Smokers/Vapers in the house? Yes No
5. Is your home air conditioned? Yes No If yes, central or window?
6. Do you keep your windows closed? Yes No
7. Do you have a humidifier? Yes No if yes, central or room?
8. Do you have an electrostatic air filter? Yes No
9. Do you have moisture problems in your home? Yes No
10. Do you have a basement? Yes No Is it damp? Yes No

Bedroom

1. Type of bed? Regular Waterbed/waveless Waterbed/wave
2. Plastic encasement of mattress? Yes No On pillow? Yes No
3. Stuffed animals in bedroom? Yes No How many? ______
4. Type of pillow: Feather Synthetic Cotton
5. Do you have: Carpet Wood Vinyl flooring

VI. WORK/SCHOOL

1. What is your occupation? ______
2. A student? Yes No What grade are you in? ______
3. What are your hobbies? ______
4. Are your symptoms worse at work? Yes No
5. Do you get better on vacation? Yes No
6. How many days did you miss school or work in the past year? ______
7. If child, is he/she in daycare? Yes No
8. How many children in room? ______

How long have you lived in Georgia? ______ years
Where else have you lived? ______

VII. FAMILY HISTORY

Does any member of your family have a history of:

	Who: (father, mother, grandmother, etc.)
Asthma	
Hay fever	
Eczema	
Migraines	
Recurrent infections	
Cystic Fibrosis	
Insect Sting Reactions	
Other	

PROVIDER COMMENTS
(Do not write in this space)

ATLANTA ALLERGY & ASTHMA

VIII. GENERAL MEDICAL HISTORY

HOSPITAL STAYS?

Date	Reason

PROVIDER COMMENTS
(Do not write in this space)

MEDICAL PROBLEMS

Review of Systems - Please circle any applicable problems

Constitutional: fever weight loss weight gain fatigue irritability

Eyes: swelling around eye discharge contact lens glaucoma cataracts

HENT: hearing loss recurrent ear infections hayfever runny/itchy nose

Cardiac: palpitations chest pain high blood pressure heart disease

GI: nausea vomiting heart burn stomach pain diarrhea liver disease ulcer

GU: pain of urination difficulty urinating frequent urination blood urinary infections prostate problems

Musculoskeletal: joint swelling bone pain frequent broken bones osteoporosis

Is child growing well? Yes No

Skin: eczema hives itching sores in mouth thrush

Neurologic: headaches numbness seizures weakness migraines

Psychiatric: Allergies affecting the quality of life? Yes No

Hematologic: anemia swollen glands bleeding HIV positive

Other Problems (circle all that apply)

Arthritis	Diabetes	Thyroid disease
Cancer	Tuberculosis	Bowel disease
Asthma	Allergies	Hayfever

SURGERY/OPERATIONS

Circle surgeries and give year ________________

Ear tubes Nasal/Sinus surgery Tonsillectomy/Adenoidectomy

Other ________________

Have you had chicken pox? Yes No Vaccine

SMOKING HISTORY Yes No How much? ________ How often? ________

For how many years? ________ When did you stop? ________

VAPING HISTORY Yes No How much? ________ How often? ________

For how many years? ________ When did you stop? ________

Have you had all your childhood immunizations? Yes No

Do you get a flu shot every year? Yes No

Have you had the Pneumovax vaccine? Yes No

IX. MEDICATION ALLERGY

Medication	Reaction	Date

X. OTHER ALLERGIES

Do you have eczema or hives? (circle) Yes No

Have you ever had an allergic reaction to an insect sting? Yes No

If yes, what happened? ________________

Are you allergic to any foods?

Food	Reaction	Date

Have you ever had itching, sneezing or swelling after dental exam or GYN exam? Yes No

Have you ever had a reaction after using any of the following? (circle)

balloons rubber products elastic bandages condom

ATLANTA ALLERGY & ASTHMA

Urticaria/Angioedema Section

PROVIDER COMMENTS
(Do not write in this space)

(Fill out only if you are being seen for Hives or Swelling)

1. How long have you had hives/swelling? ____________________
2. Briefly describe the circumstances surrounding their onset:

____

____

____

2a. How often do you experience hives? ____________________

3. What medications are you taking for the hives/swelling? ____________________

____

4.	How long does each individual hive last?	<24 hours	>24 hours
5.	Do they itch?	Yes	No
6.	Are they painful?	Yes	No
7.	Do you experience shortness of breath, wheeze, chest tightness, abdominal pain, throat fullness, dizziness or diarrhea? (circle applicable symptoms)	Yes	No
8.	Have you recently experienced fevers, chills, night sweats, swollen glands, swollen joints, weight gain or loss? (circle applicable symptoms)	Yes	No

9. What "triggers" the hives/swelling (circle)

stress	vibration	exercise	medications
friction	home	food	pressure
work	heat	sunlight	cold
water	other	do not know	

11. Do you have a family history of hives/angioedema? Yes No
Who? ____________________

12. Have you ever had hives / angioedema in the past? Yes No
If yes, when & how long did they last? ____________________

Insect Section

(Fill out only if you are being seen for Insect Allergy)

1. My reaction to an insect sting occurred on: Month________Year ________
2. Please describe the location of sting and what happened at the time of the sting.

____

____

3. What caused the sting? Bee Wasp Yellow Jacket Hornet Ant Unknown
4. The symptoms that occurred after the sting included (please circle)

swelling at the site	trouble breathing
distant swelling (i.e. lips, tongue)	trouble swallowing
hives	vomiting
loss of consciousness	dizziness

5. I received treatment at an emergency room Yes No
If yes, which one? ____________________

They gave me	Benadryl	Epinephrine	Steroids
	IV fluids	I don't know	

6. I have an EpiPen, Auvi-Q, or other epinephrine auto-injector. Yes No
7. Have you ever been stung before? Yes No
8. If yes, when and describe the reaction ____________________

____

____

ATLANTA ALLERGY & ASTHMA

ATLANTA ALLERGY & ASTHMA

Electronic Communication Agreement

Patient Name: ____ DOB: ________________

By signing below, I agree that Atlanta Allergy & Asthma (AA&A) may send the following types of emails and text messages (including automated messages) to the mobile telephone number and/or email address, as applicable, that I have provided to AA&A:

- appointment confirmations and reminders;
- other practice communications such as clinical care reminders and information, pre- or post-visit instructions, messages regarding my health and health plan and/or diagnoses or treatment, billing-related messages, eligibility information or questions, and occasional practice updates such as office moves or weather closings;
- updates on available treatment offerings and services, promotions, and services and programs that may be of interest to me, refill reminders.

Electronic communication authorization options. Initial below to indicate consent:

______ Email

______ Text Messaging

<u>I understand that I have the right to opt-out of receiving certain such communications by following the instructions provided in an applicable message</u>. However, I understand that if I choose to opt out, I may experience an impact in my experience with the service(s) that rely on communications via text messaging and/or email communications. I also understand that I may continue to receive certain time-sensitive messages that do not require consent (such as emergency notifications) even after opting out or unsubscribing.

I agree that AA&A may send me messages by text or email (as selected above) that are unsecure. Text messages and email communications have inherent privacy risks, including that unencrypted text messages and email communications are not secure and could be accessed by an unauthorized party, intercepted, or altered without my knowledge or authorization.

_____________________________________ _________________________________ __________

(Signature of patient/authorized representative) (Print name if other than patient) (Date)

By opting-in to email communication from AA&A, you agree to receive the types of emails described above. You can revoke your consent to receive emails at any time by using the unsubscribe link found at the bottom of every email.

By opting-in to SMS messages from AA&A, you agree to receive automated promotional messages. This agreement is not a condition of any purchase. Msg & Data rates may apply. Reply STOP to end any time after receiving your initial confirmation message.

Terms of Service and Privacy Policy can be found on our website.

ATLANTA ALLERGY & ASTHMA

AA&A Financial Policy/Appt. Cancellation Policy

To accommodate the needs and requests of as many patients as possible, AA&A is contracted with numerous insurance companies. While we are pleased to be able to provide this service to you, it is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services received. Within the same insurance company, benefits may differ depending upon what type of contract your employer negotiated with that carrier on your behalf.

Providing quality medical care for our patients is our primary concern.
We are happy to provide care for our patients within their insurance contract guidelines, but we ask that our patients come prepared at the time of service to let us know what those guidelines are. With most of our contracts, Atlanta Allergy personnel are not permitted to interpret insurance benefits for the patient. We are expected and obligated to provide quality care to each insured person, but **it is the insured person's responsibility to understand their benefits.**

Should your insurance company require a **specialist referral** from your primary care physician before you can be seen, it is your responsibility to obtain that referral **prior to your appointment.** You should bring the referral with you to your appointment. Our contracts with those insurance companies prohibit us from seeing you without a referral and subsequently billing them for the services. If you are seen without a referral, **you must be prepared to pay for all services in full at the time they are rendered.** If a referral is required and you are unsure as to how to obtain one, please let the staff know and we will be happy to provide assistance.

If you do not inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment, and we subsequently order services that are not covered, we will have no choice but to bill you directly for those charges. In the event that services are provided and your insurance coverage is not in effect on that day, or if your contract contains a pre-existing clause, your insurance carrier will likely deny payment for services received. **Please remember that you, the patient, are ultimately responsible for payment on your account.**

With your cooperation and help, you should be able to receive all of the insurance benefits offered to you, and we will be able to concentrate on caring for your medical needs.

Appointment Cancellation Policy

Your appointment is important to both you and your AA&A provider. If you cannot keep your appointment, please contact us **at least 24 hours prior to your scheduled appointment time**. If you do not provide notice 24 hours in advance, you may be charged a **$25 no-show fee.**

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS DESCRIBED.

______________________________ (Patient and/or Insured)

______________ (Date)

______________________________ (Print Name)

ATLANTA ALLERGY & ASTHMA

Acknowledgement of Receipt of Notice of Privacy Practices

Part 1:

Patient Name: ____

Address: ____City, State, Zip: ____________________________________

I have been given a copy of **Atlanta Allergy & Asthma** *Notice of Privacy Practices (“Notice*”), which describes how my health information is used and shared. I understand that **Atlanta Allergy & Asthma** (“*the Practice”*) has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Official, or by visiting the Practice website at www.atlantaallergy.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

____ ___________________

(Signature of Patient or Personal Representative) (Date)

Print Name & Title (e.g., Guardian, Health Care Power of Attorney): ____

Part 2:

Atlanta Allergy & Asthma clinical staff may need to communicate Protected Health Information (PHI), such as test or lab results, via phone. Please let us know what phone number you would like us to call and if we may leave a message:

Phone Number: ____

___ Yes, you may leave a message
___ No, please do not leave a message

I authorize the Practice to include the following person(s) in any communication regarding my PHI. This is a valid authorization until I revoke this in writing:

Name: ____ Relationship: ___________________________________

____ _______________________________ _______________

(Signature of Patient or Patient Representative) (Contact Number) (Date)

For Practice Use Only: Complete this section if you are unable to obtain signature. If the Patient or personal rep is unable or unwilling to sign the Privacy Acknowledgement, or it is not signed for any other reason, state the reason:

____

Describe the steps taken to obtain the Patient’s (or personal reps) signature on the Acknowledgement:

____

Signature of Practice Representative: ____ Date: ___________

Patient Account #:_______________________________________

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ATLANTA ALLERGY & ASTHMA

Marketing and Referral Questionnaire

Thank you for choosing Atlanta Allergy & Asthma. Please take a moment and let us know how you heard about our practice.

PATIENT NAME:______________________________________**APPT DATE**: _____________

How did you hear about our practice? (Please indicate ALL that apply)

☐ Your Physician: ____
(NAME)

☐ Insurance Co. Booklet/Website: ____
(PLAN)

☐ Atlanta Allergy & Asthma Employee: _______________________________________
(NAME)

☐ Friend/Family Member: ____
(NAME)

Check ALL that apply:

☐ AAA Website	☐ Outdoor Billboards
☐ Google	☐ WSB AM Radio/Scott Slade
☐ Other Search Engine (Yahoo/Bing)	☐ Local News (Radio/TV/Print)
☐ Yelp	☐ Social Media (Facebook/Twitter)
☐ HealthGrades.com	☐ Health Fair/Community Event
☐ Vitals.com	☐ Urgent Care/Pharmacy-based Clinics
☐ Yellow Pages	☐ Other: ________________________

Staff:

ACCOUNT NUMBER:________________________________**OFFICE LOCATION:** ___________

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ATLANTA ALLERGY & ASTHMA

ALLERGY SKIN TEST INFORMATION

- It is important to be on time for your skin test appointment. If you arrive late, we may be unable to test you due to time constraints. Please arrive 15 minutes early to complete the registration process.
- If your insurance requires a referral, please make sure we have it in advance of the appointment. On the day of the appointment, please bring insurance card, photo ID, and form of payment.
- Allow 2-3 hours for skin testing. You will discuss the results after testing is complete. When children are being tested, it's a good idea to brings items to entertain them throughout the process.
- **DISCONTINUE ALL ANTIHISTAMINES FOR SEVEN (7) DAYS PRIOR TO TESTING. Antihistamines will block the skin test reaction and may prevent accurate test results.** This includes any allergy, cough, cold, 'night-time' or sleep-aid medications (details on 'Medication List' form). Bring a list of any OTC or prescription medications you are currently taking.
- Wear comfortable clothing. Staff will need access to your back and arms, so do not wear a one-piece outfit.
- It is recommended you eat prior to your skin test appointment. Because we treat patients with severe food allergies, we do not allow food in the clinics.
- Please avoid wearing scented sprays, lotions, and perfumes as they may cause reactions in sensitive patients.
- Skin testing is a simple series of tiny scratches made on your back with a plastic instrument that has small toothpick-like prongs each containing trace amounts of a single allergen. Your doctor determines the number of tests done according to your medical history and symptoms. Skin testing is not painful but can be somewhat uncomfortable.
- After skin prick testing some patients may also receive intradermal testing. With intradermal tests, a small amount of the allergen is injected under the skin of the arm to see if it causes a reaction.
- Swelling or redness at the skin test sites may appear several hours after testing. These "delayed reactions" do not have any significance. Any itching associated with these reactions can be managed with steroid creams and antihistamines. These symptoms may persist for several days.

Special COVID Protocols:

-Per CDC guidance for medical facilities, please continue to wear face coverings while in our offices
-Limit the number of guests that accompany the patient to the office
-If you are experiencing any flu-like symptoms, please call to reschedule your appointment

ATLANTA ALLERGY & ASTHMA

Allergy Skin Testing – Medication List

Important Information about Allergy Skin Testing:

Patients scheduled for allergy skin testing must stop taking any medications that contain antihistamines as they will affect the results of your test. This includes both over-the-counter as well as prescription medications. Do not discontinue antidepressants/psychotropic medications or any other medications without consulting with your prescribing physician. Call your pharmacy or prescribing physician if you are unsure about the names of your medications. **Asthma medications do not affect skin testing. Do not stop your asthma medications.**

The following is a list of medications that must be STOPPED SEVEN (7) DAYS before skin testing:

Actifed
Adapin
Advil Allergy
Advil PM
Alavert
Allegra
Allerhist
Allertan
Amitriptyline
Anafranil
Antivert
Asendin
Ataraz
Atrohist
Aventyl
BC Cold
Benadryl
Bentyl
Benztropin
Biohist
Bonine
Brompheniramine
Carbinoxamine
Cetirizine
Chlortrimeton
Clarinex
Claritin
Clemastine
Clomipramine
Cogentin
Comtrex
Contac
Coricidin
Cyproheptadine
Desipramine
Dimetapp
Diphenhydramine
Doxepin
Dramamine
Drixoral
Durahist
Duratan
Dytan
Elavil
Etrafon
Excedrin PM
Fexofenadine
Hydroxyzine
Imipramine
Limbitrolr
Loratadine
Ludiomil
Levocetirizine
Marezine
Meclizine
Norpramin
Nortriptyline
Nyquil
Pamelor
Pediacare
Pediatan
Periactin
Phenergan
Polyhistine
Promethazine
Protriptyline
Pyribenzamine
Remeron
Resperidone
Risperdal
Robitussin Cough, Cold & Allergy
Rynatan
Ryneze
Semprex
Seroquel
Sinequan
Singlet
Sominex
Sudafed Cold & Allergy
Surmontil
Tacaryl
Tandur
Tavist
Temaril
Theraflu
Tofranil
Triaminic
Triavil
Trimipramine
Trinalin
Tylenol Allergy
Tylenol Cold
Tylenol PM
Unisom
Vicks
Vivactil
Xyzal
Zonolon
Zyrtec

Note: This list includes the most common antihistamines; however there may be some not listed here. Any over-the-counter medications with the word "Allergy", most over-the-counter cough and cold medications, and over-the-counter sleep medications may affect testing and should be stopped prior to your appointment. If you have any questions, please call us at 770.953.3331.

The following medications must be STOPPED TWO (2) DAYS before skin testing:

GI MEDICATIONS (for reflux and indigestion)

Axid
Cimetidine
Famotidine
Nizatidine
Pepcid
Ranitidine
Tagamet
Zantac

ANTIHISTAMINE NASAL SPRAYS/EYE DROPS

Azelastine
Astelin
Astepro
Patanase
Dymista