



ATLANTA ALLERGY & ASTHMA

AAA Physician: _____

Referring Physician: _____

(Address) _____

PATIENT MRN#: _____

DATE: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Birth Date: _____ Sex: _____ Race: _____ Ethnicity: _____

Billing Address: _____

State: _____ Zip: _____ County: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: _____ Student Status (Y/N): _____ Veteran Smoker

Email: _____ Language: _____

Ins. Company: _____ Medicare #: _____ Medicaid #: _____

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 the child lives with is the responsible party:

Responsible Party: _____ DOB: ____ / ____ / ____

Address: _____

State: _____ Zip: _____ Telephone: _____

Employer: _____ Emp Telephone: _____

Occupation: _____ Ins. Company: _____

SPOUSE INFORMATION OR OTHER PARENT

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

Date of Visit: _____

Name: _____

Age: _____

Date of Birth: _____

Phone: Home () _____

Work: () _____

Primary Care Doctor: _____

Referring Doctor: _____

Pharmacy: _____ Phone #: _____

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

PROVIDER COMMENTS
(Do not write in this space)

How long have you had these problems? _____

I was asked to see this pt in
consultation by

How frequently do you have them? _____

Dr. _____ for

I. ALLERGY HISTORY

Nasal Symptoms/Causes

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

- 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 the things that cause your symptoms (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 seasonal? Circle one or both

If seasonal, months symptoms occur: _____

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

II. RESPIRATORY HISTORY

1. Circle any appropriate 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 2-8

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 circumstance appropriate 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: _____



III. MEDICATIONS

I take the following medications, including 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

- Do you use a spacer with your inhaler? Yes No
If yes, which type? _____
- Do you own a home nebulizer? Yes No
- 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 allergy injections? Yes No
If yes, when _____ Did they help? Yes No

V. ENVIRONMENTAL SURVEY - HOME

General (Circle where appropriate)

- Where do you live? House Apartment Trailer Condo Other
- How long have you lived there? _____ How old is it? _____
- Pets (If yes, please specify): Yes No

Cat	indoor	outdoor	both		
Dog	indoor	outdoor	both		
Other	indoor	outdoor	both		
- Smokers in the house? Yes No
- Is your home air conditioned? Yes No If yes, central or window? _____
- Do you keep your windows closed? Yes No
- Do you have a humidifier? Yes No if yes, central or room? _____
- Do you have an electrostatic air filter? Yes No
- Do you have moisture problems in your home? Yes No
- Do you have a basement? Yes No Is it damp? Yes No

Bedroom

- Type of bed? Regular Waterbed/waveless Waterbed/wave
- Plastic encasement of mattress? Yes No On pillow? Yes No
- Stuffed animal in bedroom? Yes No How many? _____
- Type of pillow: Feather Synthetic Cotton
- Do you have: Carpet Wood Vinyl flooring

VI. WORK/SCHOOL

- What is your occupation? _____
- A student? Yes No What grade are you in? _____
- What are your hobbies? _____
- Are your symptoms worse at work? Yes No
- Do you get better on vacation? Yes No
- How many days did you miss school or work in the past year? _____
- If child, is he/she in daycare? Yes No
- 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)



**VIII. GENERAL MEDICAL HISTORY
HOSPITAL STAYS?**

Date	Reason
_____	_____
_____	_____
_____	_____

MEDICAL PROBLEMS

Review of Systems - Please circle any appropriate 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

Which ones and what year? _____
 Ear tubes Nasal/Sinus surgery Tonsillectomy/Adenoidectomy
 Other _____

Have you had chicken pox? Yes No Vaccine
SMOKING HISTORY Yes No How much? _____
 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, PA - Financial Policy

In order to accommodate the needs and requests of as many patients as possible, Atlanta Allergy 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 by our physicians, 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 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.

Atlanta Allergy & Asthma Physicians and Staff

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)



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) (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 #: _____



Patient Communication/Appt. Cancellation Policy/Rx History

Patient Name: _____ DOB: _____

Patient Communication Options

Atlanta Allergy & Asthma (AAA) offers several options to receive practice communications such as appointment confirmations/reminders, clinical care reminders, and occasional practice updates such as office moves or weather closings. These notifications are in addition to the messages you receive through your Patient Portal. If you have not activated your portal account, please call 770 953-3331 or provide your email address below. Our staff will assist you with activation.

Check your preferred option(s) for receiving notifications. You may choose voice, text, OR email - or any combination of the three.

- Voice Message: Best Phone Number: _____
Time of day for phone call reminder ___ AM (9a-12p) ___ Noon (12p-3p) ___ PM (3p-8p)
- Text message: Cell Phone # _____
- Email: Email Address: _____

Appointment Cancellation Policy:

_____ Your appointment is important to both you and the Atlanta Allergy & Asthma staff.
Patient/ Guardian Initial **If you cannot keep your appointment for any reason, please contact us at least 24 hours prior to your scheduled appointment time. If you do not keep your appointment, or cancel without a 24-hour notice, you may be charged a \$25 no-show fee.**

Consent to Obtain External Prescription History

In order to provide the highest standard of care, it is necessary for our physicians to know your prescription medication history. Our electronic health record system will allow us to view your current and past medications which can prevent negative interactions between drugs.

_____ **I Authorize** AAA and its Affiliated Providers to view my external prescription history via our electronic health record system, eClinicalWorks. My prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and authorized staff of AAA, and it may include prescriptions going back a number of years.

_____ **I DO NOT Authorize** AAA and its Affiliated Providers to view my external prescription history via our electronic health record system, eClinicalWorks.

I understand I can change my authorization by completing a new form at any time and the change will be effective when the new form is received by Atlanta Allergy & Asthma, P.A.

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



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:

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

Staff:

ACCOUNT NUMBER: _____ OFFICE LOCATION: _____

Important Information for your Allergy Skin Test Appointment:

- It is very 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.
- Allow 2-3 hours for skin testing. You will discuss the results with your doctor after the skin test.
- Wear comfortable clothing. You will be asked to take your top off, so do not wear a one-piece outfit.
- Skin testing is a simple series of tiny scratches made on your back with an 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 the history you have given. Skin testing is not painful but can be somewhat uncomfortable. Some describe the prick test sensation as being “like a cat walking over the back.”
- 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. This test feels like pinches.
- Swelling or redness at the skin test sites, which may appear several hours after your testing, are called "delayed reactions" and do not have any significance. Any itching associated with these reactions can be managed with steroid creams and antihistamines. This may persist for several days.
- **It is important to stay off antihistamines for seven (7) days prior to testing. Antihistamines will block the skin test reaction.** (See detailed list of medications included in New Patient Packet and on our website.)
- It is recommended you eat prior to skin testing.

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

ANTIHISTAMINE NASAL SPRAYS

Azelastine	Astepro	Dymista
Astelin	Patanase	