

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

(This form applies only to the use, release and disclosure of information. It is not consent for treatment or intended for any other purpose.)

By signing this form, I consent to the use and release of all or any portion of the information obtained by Allergy and Asthma Consultants, P.C., as part of medical services provided to me for purposes of:

- **Diagnosis, treatment and care** (including information disclosed to appropriate personnel at Allergy and Asthma Consultants, P.C; other physicians, including those at other medical practices; laboratories; diagnostic centers; hospitals, other health care professionals, facilities and providers etc.
- **Obtaining Payment for Health Care Services** (filing insurance claims, collections, etc.)
- **Health care Operations** (this is a term used in federal privacy protection legislation that relates to quality control and review, business operations, general administrative purposes, and compliance with state and federal laws, etc.)

This consent for use/disclosure of protected health information does not apply to disclosure for other purposes, in which case Allergy and Asthma Consultants, P.C. will obtain specific authorization from me. There are a few exceptions in the law permitting use/disclosure of information without my authorization. Please see the *Notice of Privacy Practices* for details.

I understand that Allergy and Asthma Consultants, P.C. assumes no responsibility for the use or misuse *by others* of my health information disclosed under this consent.

I have been offered the opportunity to review Allergy and Asthma Consultants *Notice of Privacy Practices*. I have discussed any concerns that I may have about the use/disclosure of my health information with the Privacy Officer at Allergy and Asthma Consultants, P.C., or other appropriate personnel.

I release Allergy and Asthma Consultants, P.C. from all legal liability that may arise from this consent specifically with regard to the way my information is used by entities other than Allergy and Asthma Consultants, P.C. *provided that my information is utilized only as outlined above.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the signature above is not that of the patient, I am acting for them because

\_\_\_\_\_.

My relationship to the patient is: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Account # \_\_\_\_\_

Insurance Code: \_\_\_\_\_

### ALLERGY AND ASTHMA CONSULTANTS, P.C.

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Cumming, Georgia 30041  
(770) 889-8636  
Fax: (770) 844-7565

Building 600, Suite 620  
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Roswell, Georgia 30076  
(770) 740-9600  
Fax: (770) 740-9306

Building A, Suite A  
3400 McClure Bridge Rd.  
Duluth, Georgia 30096  
(770) 813-0254  
Fax: (770) 813-0255

We appreciate the confidence you have expressed by selecting us as your physicians. If you have any questions about our services, fees, or other aspects of your care, please discuss them with us frankly. The best medical service is based on a friendly, mutual understanding between a doctor and his patients. Our office phone number is also our night and emergency phone. It is answered by our answering service when the office is closed. All patients are expected to pay for your portion of the bill including any copays and/or deductible. At the end of the month, you will receive an itemized statement showing the transactions of your account and the amount due, if any. If you are unable to pay your bill, please contact us and we will assist you in making arrangements for payment. If you are having temporary financial problems, let us know and we will be most understanding and cooperative.

PLEASE DISCUSS TOTAL COST OF A NEW PATIENT WORKUP WITH ME \_\_\_\_\_

Pharmacy # \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

Mr.  
Mrs.  
Miss  
Ms.  
M.D./Ph.D

(Please  
Circle  
One)

#### PATIENT DATA

Patient Name \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_

Referred by and Services Requested by Dr. \_\_\_\_\_

Employer/School Name \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

Personal Physician \_\_\_\_\_ Other Physicians \_\_\_\_\_

Whom May We Thank for Referring You if not a Physician? \_\_\_\_\_

Address \_\_\_\_\_

We will be sending a report to your referring physician.  
Please list any other physician(s) & address(es) to whom you would like a report of this visit sent. \_\_\_\_\_

Has Any Member of Your Family Been Treated by Our Physicians? \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

OVER

\* Whom Should We Contact in the Event of an Emergency?

Name \_\_\_\_\_

Phone #(s) (\_\_\_\_) \_\_\_\_\_

Phone #(s) (\_\_\_\_) \_\_\_\_\_

SPOUSE INFORMATION

Spouse's Name \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Employer \_\_\_\_\_ Position Held \_\_\_\_\_

**GUARANTOR DATA**

(Person Responsible for Bill if other than Self)

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer Name \_\_\_\_\_

**INSURANCE DATA**

If you've had this insurance less than one year, your insurance became effective \_\_\_\_\_.

Primary Plan Name \_\_\_\_\_

Address \_\_\_\_\_

Insured Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Plan Name \_\_\_\_\_

Address \_\_\_\_\_

Insured Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

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(1) **I authorize** the release of a report of diagnosis, treatment, prognosis, and recommendations, as well as other data pertinent to treatment, to the physicians listed, also any medical information may be sent to my insurance company.

\_\_\_\_\_  
Signature Date

(2) **Please sign** below to allow medical benefits to be paid directly to Allergy and Asthma Consultants, P.C.

\_\_\_\_\_  
Signature Date

(3) **Our office** will make every effort to comply with your insurance company's rules regarding our referring you or obtaining X-rays and laboratory studies. Due to our participation in over 30 different plans, each with its own regulations (and several companies have several different plans, of which all are different from each other), **WE CANNOT ASSUME ANY FINANCIAL RESPONSIBILITY FOR ERRORS.** It is your responsibility to know what your plan covers and what it does not cover.

\_\_\_\_\_  
Signature Date

## Allergy & Asthma Consultants, P.C.

Date	Name	Age	Race	Sex
Referred By:		Primary Physician:		Date of Birth
My main concern and the main reason I am here is:			Date of Onset of Symptoms	

**SYMPTOMS: Please mark all the boxes that apply to you**

<input type="checkbox"/> Itchy Eyes <input type="checkbox"/> Red Eyes <input type="checkbox"/> Stuffy Nose <input type="checkbox"/> Sneezing — How many times in a row? _____ <input type="checkbox"/> Runny Nose <input type="checkbox"/> Frequent Nose Bleeds <input type="checkbox"/> Mouth Breathing <input type="checkbox"/> Headaches <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Pressure in Ears	<input type="checkbox"/> Watery Eyes <input type="checkbox"/> Burning Eyes <input type="checkbox"/> Itchy Nose <input type="checkbox"/> Mucus in Throat <input type="checkbox"/> Snoring <input type="checkbox"/> Pressure in Sinuses <input type="checkbox"/> Nasal Polyps <input type="checkbox"/> Ear Infections	<input type="checkbox"/> Cough: <input type="checkbox"/> Frequent <input type="checkbox"/> Productive of Sputum <input type="checkbox"/> Wheeze <input type="checkbox"/> Chest Tightness <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Exercise Limitation <input type="checkbox"/> Chest symptoms wake me up at night <input type="checkbox"/> Skin Rash <input type="checkbox"/> Eczema <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Swelling <input type="checkbox"/> Indigestion or Heartburn <input type="checkbox"/> Rubber or Latex Allergy
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**PLEASE MARK THE SEASONS WHEN THE SYMPTOMS OCCUR:**

	Nose/Hay Fever	Sinus	Eye	Chest/Asthma	Skin/Eczema or Hives	(Leave blank)
Year Round						
Spring						
Summer						
Fall						
Winter						

**TRIGGERS: Please mark the things that make the symptoms Worse.**

	Nasal/Sinus	Eye	Chest	Skin		Nasal/Sinus	Eye	Chest	Skin
Dusting or Vacuuming					Changes in Weather				
Cats					Changes in Temperature				
Dogs					Cigarette Smoke				
Other Animals					Odors & Perfume				
Foods					Cold Air				
Cut Grass					Air Conditioning				
Raked Leaves					Emotional Upset or Crying				
Hay					Exercise				
Dampness					Pregnancy or Menstruation				
Basements					Work or School				
Wet Weather					Other _____				

**QUALITY OF LIFE: Please mark all that apply**

- |   |  |
|---|--|
| <input type="checkbox"/> Increased fatigue or lack of pep or energy | <input type="checkbox"/> Causes me to accomplish less than I would like to |
| <input type="checkbox"/> Affects work or school performance         | <input type="checkbox"/> I miss work or school due to my problem           |
| <input type="checkbox"/> Keeps me up at night                       | <input type="checkbox"/> This makes me nervous, irritable or unhappy       |
| <input type="checkbox"/> I feel less like exercising                | <input type="checkbox"/> I get sick more than I should                     |

**PREVIOUS ALLERGY TESTING AND TREATMENT**

Have you ever been Allergy Skin Tested?  Yes  No | Results of Testing \_\_\_\_\_  
 When and Where? \_\_\_\_\_ | Did you receive Allergy Injections?  Yes  No  
 What were the effects of injections on symptoms?  Improved  No Change  Worsened  Side Effects \_\_\_\_\_

**What Other Health Problems Do You Have?**

Please check and circle all that apply

- Constitutional: Fatigue, Fever, Weight loss, Other
- Cancer: type \_\_\_\_\_
- CV: Heart Disease, High Blood Pressure, Murmurs, Other
- Endocrine: Diabetes, Thyroid, Other
- Ears-Nose-Throat: Sleep Apnea, Snoring, Other
- Eyes: Cataracts, Glaucoma, Other
- GI: Hepatitis, Hiatal Hernia, Irritable Bowel, Reflux, Ulcer, Other
- Genito-Urinary: Bladder Infections, Kidney Disease, Other
- Hematological (Blood): Anemia, Sickle Cell, Other
- Musculo-Skeletal: Arthritis, Fibromyalgia, Other
- Neurological: Epilepsy, Headache, Seizures, Strokes, Other
- Psych: Alcohol or Drug Abuse, Anxiety, Depression, Other
- Reproductive: Menopause, Other
- Resp: COPD, Emphysema, Pneumonia/Tuberculosis, Other
- Skin: Eczema, Rashes, Other
- HIV, Aids

**Review Of Systems**

This column for Physicians Only

Yes No

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**MEDICATIONS: Please list all Prescription and Over the Counter Medications you are now taking.**

Medication	Dose (mg)	How Often	Medication	Dose (mg)	How Often

**Vitamins, Herbs and Other Supplements: Please list all that you are taking.**

\_\_\_\_\_

**Previous X-Rays**

Have you had a Chest X-Ray?  Yes  No If Yes, When? \_\_\_\_\_ Where? \_\_\_\_\_  
 Have you had a Sinus X-Ray?  Yes  No If Yes, When? \_\_\_\_\_ Where? \_\_\_\_\_

**HOSPITALIZATIONS OR SURGERIES; Please list all.**

Problem or Operation	Age or Date	Problem or Operation	Age or Date

DRUG ALLERGIES: Please list all that apply to the patient		
Drug	Reaction	Date/Year

INSECT ALLERGIES: Please list all that apply to the patient		
Insect	Reaction	Date/Year

FOOD ALLERGIES: Please list all that apply to the patient		
Food	Reaction	Date/Year

FAMILY HISTORY: Please mark all that apply						
	Hay Fever	Sinus	Asthma	Eczema	Hives	Other (leave Blank)
Father						
Mother						
__ Sisters __ Brothers						
Grandparents (Father's)						
Grandparents (Mother's)						
Children: __ Male # __; __ Female # __						

SOCIAL HISTORY: Please mark all that apply		Occupation
Do you Smoke? __ Yes __ No	How many packs-per-day _____	for how many years _____
Have you ever smoked in the past? __ Yes __ No	How many packs-per-day _____	how many years _____
If you smoked in the past, when did you quit? _____	Other smokers in the home? __ Yes __ No	

ENVIRONMENTAL SURVEY: Please check all that apply.						
How long have you lived in Georgia? _____			Where else have you lived? _____			
Your Home: __ Single Family Home __ Multiple Family Dwelling __ Apartment __ Mobile Home						
The HOME	Age of House	How Long Living in Home		Heating System (type)	Type of Filter	Frequency of Filter Change
	Air Conditioning __ Central __ Room	Attic Fan __ Yes __ No	Is Fan Used __ Yes __ No	Humidifiers __ Yes __ No	Areas of Dampness, Mold or Mildew __ Yes __ No Location _____	
PATIENT'S BEDROOM	Shared __ Yes __ No	Bedding: __ Innerspring __ Waterbed	Age of Bedding _____ yrs.	Comforter __ Down __ Synthetic.	Type of Pillows __ Down __ Synthetic	Age of Pillows _____ yrs.
	Carpeted __ Yes __ No		Allergy Covers __ Yes __ No			Allergy Covers __ Yes __ No

PETS: Do you have pets IN your home? __ Yes __ No			
	How Many?	Allowed in Bedroom?	Describe any symptoms you have around the pet
Dogs		__ Yes __ No	
Cats		__ Yes __ No	
Birds		__ Yes __ No	
Other _____		__ Yes __ No	