ALLERGY AND ASTHMA CLINIC of CENTRAL TEXAS

4204 E Stan Schlueter Lp
Killeen, TX 76542
254.690.2800 P
254.690.5401 F

1508 Leander Rd
Georgetown, TX 78628
512.931.2288 P
512.931.2299 F

2000 N Mays Ste 109
Round Rock, TX 78664
512.388.1861 P
512.388.0373 F

103 N Bell Blvd A-2
Cedar Park, TX 78613
512.610.3388 P
512.610.3399 F

6600 S Mopac Ste 2180
Austin, TX 78749
512.892.3336 P
512.892.3338 F

Patient Information

Patient Name: _____ Date of Birth: _____/_____/_____
Last First Middle MM DD YYYY

Home Address: _____
Street City State Zip Code

Gender: M F Marital Status: _____ SSN: _____

Patient Home #: _____ Cell#: _____ Alt #: _____

Patient Employer: _____ Employer Phone #: _____

Emergency Contact: _____ Relationship:_____ Phone #: _____

Guarantor Information

Guarantor Name: _____ Date of Birth: _____/_____/_____
Last First Middle MM DD YYYY

Home Address: _____
Street City State Zip Code

Phone #: _____ Relationship to Patient: _____ SSN: _____

Guarantor Employer: _____ Employer Phone #: _____

Insurance Information

Primary Insurance Company: _____ Policy #: _____Group #:_____

Insurance Address: _____
Street City State Zip Code

Policy Holder Name: _____ Date of Birth: _____/_____/_____
Last First Middle MM DD YYYY

Home Address: _____
Street City State Zip Code

Phone #: _____ Relationship to Patient: _____ SSN: _____

Secondary Insurance Company: _____ Policy #: _____Group #:_____

Insurance Address: _____
Street City State Zip Code

Policy Holder Name: _____ Date of Birth: _____/_____/_____
Last First Middle MM DD YYYY

Home Address: _____
Street City State Zip Code

Phone #: _____ Relationship to Patient: _____ SSN: _____

Statement of Financial Responsibility

Private Insurance Authorization for Assignment of Benefits: I understand that Allergy & Asthma Clinic of Central Texas will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Allergy & Asthma Clinic of Central Texas and its physician(s) of medical benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductibles, coinsurance and non-covered services. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependants, including any fee or collection services needed.

If you are covered by an HMO or your insurance requires an authorization, the clinic will do it's best to ensure your authorization remains current. Ultimately, it is your responsibility to make sure that your authorization is current. In the event that services have been rendered and your authorization has expired any unpaid balances will be your responsibility.

Payment Options: Payment is due at the time services are rendered. The clinic accepts cash, MasterCard, Visa, Discover and American Express. Balances older than 60 days may be subject to additional collection fees and interest charges.

Medical Records: All medical records are the property of the Allergy and Asthma Clinic of Central Texas. Copies of medical records may be subject to a $25 fee. We require a 3 working day notice for any records needing to be copied.

Missed Appointment: There will be a $15.00 missed appointment fee for all appointments that are not cancelled by you or a family member prior to 24 hours of your scheduled appointment time. The fee will be collected at your next visit or billed to you directly.

If you have any questions about the above information, please contact the office. If you have questions regarding your insurance coverage, please contact your employer or insurance company.

_____	_____	_____
Signature of Patient (or Responsible Party)	Print Patient Name	Date

Acknowledgement of Receipt of Privacy Practices

I, _____, have received a copy of the Notice of Privacy Practices for the Allergy & Asthma Clinic of Central Texas.

I give permission for the Allergy and Asthma Clinic to discuss my health information with the following persons:

_____	_____
_____	_____
_____	_____
Print Patient's Name	Patient's DOB
_____	_____
Print Person's Name Responsible for Patient	Relationship
_____	_____
Signature of Patient/Responsible Person	Date

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Notice of Privacy Practices
HIPAA (Health Insurance Portability and Accountability Act)

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect January 1, 2004 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available on request.

Uses and Disclosure of Health Information: We use and disclose health information about you for treatment, payment and healthcare operation. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use your medication history or lab results to ensure best patient care.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operation: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health care information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To your Family and Friends: We must disclose your health information to you. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in Care: We may use or disclose health information to notify or assist in the notification of a family member, your personal representative or another person responsible for your care. We will use our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health Related Services: We will not use your health information for marketing communications without your written consent.

Required by Law: We may use your health information when we are required to do so by law

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or possible victim of other crimes.

Appointment Reminders: We may use health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

If you are concerned that we may have violated your privacy rights you may submit it to us or you may contact the US Department of Health and Human Services at 1-877-550-5754.

Allergy and Asthma Clinic of Central Texas

Brian Terry Miller, D.O. Anthony R. Henry, M.D. Uday K. Reddy, M.D.
Jentry Riddle, PA-C Melanie McKinley, PA-C Lauren Upton, PA-C
Killeen Georgetown Round Rock Cedar Park South Austin

New Patient History

Patient Name: _____ **Gender: M F Age:** _____ **DOB:** ___/___/_____
Last First MI MM DD YYYY

Ethnicity: _____ **Marital Status:** _____ **Occupation:** _____

Referred By: _____ **Primary Care Doctor:** _____ **Appt Date:** ___/___/_____
MM DD YYYY

Email address: _____ **Preferred Pharmacy:** _____

Chief Complaint(s): (*BRIEFLY* describe the reason for you visit and what you hope to accomplish today)

_____

_____

_____

HPI:

Location: (area of the body involved) _____

Severity: [ ] Mild [ ] Moderate [ ] Severe

Timing: [ ] Rare [ ] Frequent [ ] Constant

Worst Time of Year: [ ] Spring [ ] Summer [ ] Fall [ ] Winter [ ] Year-round

Duration: _____ [ ] Days [ ] Weeks [ ] Months [ ] Years [ ] Lifelong

Exacerbating Factors: (please "X" anything that makes you worse)

	Trees		Cold weather		Alcohol		Air conditioning
	Grasses		Humid weather		Food (list)		Heater
	Weeds		Dry weather				Strong Odors
	Molds		Windy days				Soaps/Detergents
	Dust		Rainy days				Chemicals
	Animals		Weather changes				Smoke
					Medication (list)		
	At work		Exercise				
	Indoors		Illness				
	Outdoors		Emotion				
	Cleaning		Stress				
	Yard work		Menstrual Cycle				

Alleviating Factors: (please list anything that makes you feel better)

_____

_____

Other associated symptoms:

_____

_____

Medications:

Drug Name	Strength	How Often	How long	Reason

Patient Name: _____ DOB:___/___/____

Review of Systems: (Do you *CURRENTLY* have any of the following? Place an "x" or check denies)

	General: [ ] None
	Fatigue
	Weight loss
	Weight Gain
	Fever

	Eyes: [ ] None
	Redness
	Itching
	Tearing
	Crusting of lids
	Pain

	Ears: [ ] None		
	Congestion		Ringing
	Itching		Vertigo
	Pain		Popping
	Discharge		
	Tubes		

	Nose: [ ] None
	Itching
	Sneezing
	Congestion
	Drainage [ ] clear [ ] white [ ] yellow [ ] green
	Sinus pressure/pain
	Decreased or loss of sense of smell

	Mouth: [ ] None
	Itching of lips/tongue
	Swelling of lips/tongue
	White patches on tongue/soft palate
	Mouth breathing
	Dry mouth
	Bad breath

	Throat: [ ] None
	Itching
	Throat clearing
	Hoarseness
	Difficulty swallowing
	Post nasal drainage
	Sore Throat

	Lungs: [ ] None
	Chest tightness/pressure
	Shortness of breath
	Wheezing
	Coughing [ ] productive [ ] nonproductive
	Exercise-induced symptoms

	Heart: [ ] None
	Chest pressure
	Radiation to arms/neck/jaw
	Rapid heart rate
	High blood pressure

	Gastrointestinal: [ ] None
	Nausea
	Vomiting
	Diarrhea
	Constipation
	Bloating
	Crampy abdominal pain

	Genitourinary: [ ] None
	Urgency
	Frequency
	Painful urination
	Blood in urine

	Musculoskeletal: [ ] None
	Arthritis
	Weakness
	Leg swelling
	Leg cramps

	Skin: [ ] None
	Itching
	Rash
	Eczema
	Hives
	Swelling

	Neurological: [ ] None
	Headaches
	Numbness
	Imbalance
	Fainting
	Seizures

	Psychiatric: [ ] None
	Anxiety
	Panic Attacks
	Depression
	ADD/ADHD

	Endocrine: [ ] None
	Cold intolerance
	Heat intolerance
	Increased thirst
	Frequent urination

	Blood/Lymphatic: [ ] None
	Anemia
	Bleeding
	Easy bruisability

	Allergic/Immunologic: [ ] None
	HIV/AIDS
	Anaphylaxis
	Recurrent infections
	Food Allergy
	Stinging Insect Allergy

	OSA Symptoms: [ ] None
	Excessive daytime sleepiness
	Restless sleep
	Snoring
	Awakening at night
	Nightmares
	Bruxism (gritting teeth)
	Jaw clenching
	Having to urinate at night
	Night sweats

	Pregnancy: [ ] N/A
	Pregnant
	LMP
	Breastfeeding

Past Medical History: (please "x" all that apply) [ ] No significant past medical history

	ADD/ADHD
	Adrenal insufficiency
	Anaphylaxis
	Anemia
	Angioedema/swelling
	Anxiety
	Arthritis [ ] OA [ ] Rheumatoid
	Asthma
	Autism
	Bipolar Disorder
	Cancer (specify)
	Cataracts
	Cerebral palsy
	Congestive Heart Failure
	Chronic Fatigue Syndrome

	Colitis
	Contact Dermatitis
	COPD
	Cystic Fibrosis
	Depression
	Diabetes
	Ear Infection
	Eczema
	Fibromyalgia
	GERD (Heartburn)
	Glaucoma
	Hay Fever (allergies)
	Heart Disease
	Hepatitis
	HIV/AIDS

	Hives
	Hypertension
	Hyperthyroidism
	Hypothyroidism
	IBS
	Immunodeficiency
	Kidney disease
	Kidney Stones
	MI (Heart attack)
	Migraine
	Murmur
	Nasal polyps
	Osteoporosis/Osteopenia
	Panic Attacks
	Pneumonia

	Pneumothorax
	Preterm birth
	PTSD
	Pulmonary Emboli
	Recurrent Infections
	RSV
	Sinusitis [ ] recurrent [ ] chronic
	Sleep apnea
	Stroke
	Substance abuse
	Tuberculosis
	Ulcers
	Vascular disease
	Vitamin D deficiency
	↑ cholesterol/triglycerides

Past Surgical History: (please "x" all that apply) [ ] No past surgical history

	Tubes in ears
	Nasal septum repair
	Sinus surgery
	Rhinoplasty

	Adenoidectomy
	Tonsillectomy
	Angioplasty
	Stent

	Heart Bypass
	Gastric bypass
	Gallbladder
	Appendectomy

	C-section
	Hysterectomy
	Vascular
	Other

Patient Name: _____ DOB:___/___/____

Family History: (please "x" all that apply) [ ] No significant family history

	Mom	Dad	Sibling	Child	Grandparent
Hay Fever (allergies)					
Asthma					
Eczema					
Food Allergy					
Autoimmune disease					
Thyroid disease					
Migraines					
Hypertension					
Diabetes					
Sinus Disease					
Heart Disease					
Cancer					

Social History:

How many children do you have? _____Ages: _____
Do you exercise? [ ] Yes [ ] No How often? _____How long? _____
Do you drink alcohol? [ ] Yes [ ] No What kind? _____ How often? _____ How much?_____
Do you smoke? [ ] Yes [ ] No # of cigarettes per day _____ For how long? _____
Have you ever smoked? [ ] Yes [ ] No # of cigarettes per day _____ For how long? _____ Quit date _____
Are you exposed to second-hand smoke? [ ] Yes [ ] No
Have you ever used illicit drugs? [ ] Yes [ ] No What/When? _____

Home/Work/Environmental Survey:

Where do you live? _____
Indoor pets/animals and what kind? _____
Type of pillow: [ ] foam [ ] feather [ ] down [ ] synthetic
Type of bed: [ ] mattress/box spring [ ] foam [ ] air [ ] waterbed [ ] Other _____
Flooring: [ ] carpet [ ] tile [ ] laminate [ ] linoleum
Air conditioning: [ ] central [ ] window unit [ ] fans [ ] none
Where do you work: _____
Have you missed time from work due to allergies/ asthma? [ ] No [ ] Yes How much? _____

Immunizations:

Are you up to date on routine childhood immunizations? [ ] No [ ] Yes
Do you receive an annual influenza vaccine? [ ] No [ ] Yes
Have you received a pneumococcal vaccine? [ ] No [ ] Yes

Allergies:

Foods: [ ] None
[ ] egg [ ] milk [ ] peanut [ ] tree nut [ ] wheat [ ] fish [ ] shellfish [ ] other _____
Describe reaction: _____
Stinging Insects: [ ] none
[ ] honey bee [ ] yellow jacket [ ] hornet [ ] wasp [ ] fire ant [ ] mosquito [ ] other _____
Describe reaction: _____
Drugs: [ ] None
[ ] Penicillin [ ] Amoxicillin [ ] Cephalosporins [ ] Macrolides [ ] Sulfa [ ] Quinolones [ ] ASA/NSAIDS
[ ] Local anesthetics [ ] X-ray dye [ ] Other _____
Describe reaction: _____
Latex: [ ] No [ ] Yes
Describe reaction: _____

Previous Allergy Evaluation:

Have you ever been seen by an allergist?[ ] Yes [ ] No Who? _____
Have you ever had allergy skin testing? [ ] Yes [ ] No Food/or Environmental?_____
If yes, any positive reactions? [ ] Yes [ ] No To what? _____
Have you ever received allergy shots? [ ] Yes [ ] No When? _____ How long _____
Did you symptoms improve while on shots? [ ] Yes [ ] No
Have you ever experienced an adverse reaction to an allergy shot? [ ] No [ ] Yes
What happened? _____

Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?
Even if you haven't done some of these activities recently, think about how they would have affected you

Use the following scale:
0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of dozing**
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place (theater, meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you've had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3

Total: _____

A score of less than 10 suggests you may not be suffering from excessive daytime sleepiness
A score of 10 or more suggests you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

Asthma Control Test (please fill out if you have asthma)

Please choose the number that best describes your answer.

In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or home? **Score**

1 All the time **2** Most of the time **3** Some of the time **4** A little of the time **5** None of the time _____

During the past 4 weeks, how often have you had shortness of breath?

1 More than once a day **2** Once a day **3** 3 to 6 times per week **4** Once or twice a week **5** Not at all _____

During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

1 Four or more nights per week **2** 2 to 3 nights per week **3** Once a week **4** Once or twice the past month **5** Not at all _____

During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (Albuterol, ProAir, Ventolin, Proventil, Xopenex, Combivent, Primatene mist)?

1 3 or more times per day **2** 1 or 2 times per day **3** 2 or 3 times per week **4** Once a week or less **5** Not at all _____

How would you rate your asthma control during the past 4 weeks?

1 Not controlled at all **2** Poorly controlled **3** Somewhat controlled **4** Well controlled **5** Completely controlled _____

TOTAL _____