EXEMPLAR ALLERGY & ASTHMA REGISTRATION FORM

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PATIENT INFORMATION

Patient Name (Last, First, Middle): _____

DOB: _____ **SS #:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Is this a cell phone? YES / NO**

If yes, who is your cell phone carrier for Text Messaging Notifications? _____

Alternative Phone #: _____ _____

E-Mail Address: _____

Priamry Care Physician: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

PCP Phone #: _____

Preferred Pharmacy: _____

City: _____ **State:** _____ **Zip Code:** _____

How did you hear about Exemplar? _____

If patient is a minor, please complete below:

Parent or Guardian Name: _____

DOB: _____ **SS #:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Insurance: _____

Name of Insured: _____ **DOB:** _____

Secondary Insurance: _____

EXEMPLAR ALLERGY & ASTHMA **Medical History Form**

Patient Name: _____ DOB: _____

My primary reason for this appointment (circle one): Nose or Eye Allergy / Sinus Problem / Asthma / Cough /

Welts or Hives / Edema or Swelling / Persisting Rash / Other: _____

1. NOSE , EYE, or SINUS PROBLEMS

MY SYMPTOMS (circle all that apply)

ITCHY / WATERY / RED EYES / ITCHY NOSE OR SNEEZNG / RUNNY NOSE / POST NASAL DRIP /

NASAL CONGESTION / THROAT CLEARING / SINUS PRESSURE / SINUS PAIN / FREQUENT HEADACHES /

UPPER TEETH HURTING / BAD BREATH / LOSS OF TASTE OR SMELL

How long have you had this problem? _____ years/months

Worst Season: All Year / Spring / Summer / Fall / Winter

Known causes: _____

Symptoms Better: Indoors / Outdoors / on Vacation / Other _____

Times when Symptoms are BETTER: _____

Medications that Help: _____

How Many Sinus Infections per Year? _____ SINUS CT or XRay: _____

Sinus Surgery: _____ ENT surgeon who treated you? _____

Hypertension? YES / NO Beta-blocker medication used? YES / NO

Have you ever had Allergy Testing? YES / NO When? _____(year) Where? _____

Treated with Injections? YES / NO When? _____ Did Allergy Shots Help? YES / NO

Reason for Stopping? _____

2. PULMONARY RESPIRATORY SYMPTOMS

Do you have Asthma? YES / NO Who currently manages your asthma? _____

Hospital admission for asthma? YES / NO (when?) _____

Recurrent cough? YES / NO for how long? _____ Wheezing? YES / NO for how long? _____

Rescue inhaler (albuterol) use how often? _____ x per day, or _____ x per week. Wake up to use at night? YES / NO

Exercise causes?: Short of breath / cough / wheeze Heartburn / acid reflux? YES / NO Reflux at night? YES / NO

3. ENVIRONMENTAL ALLERGENS AND IRRITANTS

Circle any of the following which aggravate your nose/sinus/lung or skin problem:

HOUSE DUST / CLEANING / WOOD STOVE / COLD AIR / HUMIDITY / WEATHER CHANGES / HAY

GRASS / MOWING LAWN / TOBACCO SMOKE / CATS / DOGS / STRONG ODORS / FUMES / ANXIETY

OTHER ANIMALS OR ALLERGENS _____

CHEMICALS: _____

OTHER?: _____

4. URTICARIA (HIVES) / ANGIOEDEMA, ECZEMA OR RASH

(If your problem does not include skin problems, please check here ☐ and continue to the next section.)

My skin problem includes (circle all that apply): ITCHING / HIVES / SWELLING / ECZEMA /

DERMATITIS / SEVERLY ITCHY SKIN / WELTS / RASH

How long ago did skin problem begin? _____

I last had skin problem _____ Continuous? YES / NO

Episodic skin problem occurs every _____hrs/days/weeks/months.

Where on the body do they occur? _____

They look like? _____

Do they change location within a day? YES / NO When gone, do they leave marks on the skin? YES / NO

Things you think could cause them? HEAT / COLD / PRESSURE / TIGHT CLOTHING / SUN LIGHT

VIBRATION / EXERCISE / ANXIETY / LATEX / WATER / FOOD / MEDICATION / VITAMIN

OTHER: _____

Associated Symptoms? (circle all that apply): NONE / ASTHMA / WHEEZING / THROAT TIGHTNESS

NAUSEA / VOMITING / DIARRHEA / FAINTING / DIZZY / NASAL POLYPS

OTHER: _____

Medications which helped control symptoms: _____

Medications that have not helped: _____

Other treatments or tests done: _____

5. MEDICAL QUESTIONAIRE

Do you or someone in your family have the following?:

Thyroid Problems _____ you _____ family
Allergies _____ you _____ family
Hepatitis (liver disease) _____ you _____ family
Autoimmune Disease _____ you _____ family
Athlete's Foot _____ you _____ family
Hay Fever _____ you _____ family
Emphysema _____ you _____ family
Arthritis _____ you _____ family

Asthma _____ you _____ family
Eczema _____ you _____ family
Chronic Swelling _____ you _____ family
Lupus or Vasculitis _____ you _____ family
Fungus Infection _____ you _____ family.
Sinus Issues _____ you _____ family
Cystic Fibrosis _____ you _____ family
Nasal Allergies _____ you _____ family

Other: _____

Do you have problems with feeling cold, constipation, unusually fatigued? YES / NO

Have you changed soaps, detergents, cosmetics, hair products, cleaning products recently? YES / NO

Bath / Shower Soap Brand? _____ Do you use Fabric Softener? YES / NO

Do you use Dryer Sheets? YES / NO Changes in job / school recently? YES / NO

New pets or hobbies? YES / NO Anything cause higher than normal stress? YES / NO

NSAIDS USED (circle all that apply): ASPIRIN / IBUPROFREN / MOTRIN / ADVIL / NAPROSYN / ORUDIS

RELAFEN / TOLECTIN / VOLTAREN / PONSTEL / INDOCIN / CLINORIL / OTHER: _____

How often do you use NSAIDS? DAILY / WEEKLY / EVERY OTHER DAY / MONTHLY / AS NEEDED

Allergic to bee, yellow jacket or wasp sting? (please describe) _____

Are you a smoker? YES / NO How many years? _____ How many packs per day? _____

Are there other smokers in the household? YES / NO Previous Smoker? YES / NO

Are your immunizations up to date? YES / NO Immunization Allergy? YES / NO Did you get a flu shot? YES / NO

Have you had a Pneumovax (pneumonia) shot? YES / NO when? _____

Surgical History: _____

Home: Do you live in a HOUSE / APARTMENT / MOBILE HOME Near; LAKE / WOODS / FACTORY / FARM

Any Water Damage, Flooding, or Excessive Mold Growth? _____

Humidifier used? YES / NO FORCED AIR / HOT WATER / BASEBOARDS / WOOD STOVE / OTHER _____

Do you have problems with: LADYBUGS / COCKROACHES / STINK BUGS

Indoor Pets? CATS / DOGS / BIRDS / REPTILES / HAMSTERS / GUINEA PIGS

OTHER: _____ OUTDOOR PETS? _____

HOBBIES? _____

CURRENT MEDICATIONS

Medication	Dose	Frequency	Medication	Dose	Frequency

MEDICATION ALLERGIES **No Known Drug Allergies** ☐

Medication	Allergic Reaction	Oral/IV/Topical	Dose	Year	Repeated

FOOD ALLERGIES **No Known Food Allergies** ☐

Food	Reaction

LATEX ALLERGY / SENSITIVITY

Latex is the pliable/stretchable material made for the sap of the rubber tree and used in balloons, condoms, elastic bands, padding, and medical materials.

1. Have you ever had a latex reaction or been told you have an allergy or sensitivity to latex? YES / NO
2. Have you ever had swollen lips or throat after blowing up a balloon or having dental work? YES / NO
3. Have you ever had a reaction (rash, swelling, itching of hands or eyes, hives, difficulty breathing) after being in contact with any of the following (circle all that apply):
   Rubber/latex Gloves Ace Bandages Elastic in clothing Foam Pillows Rubber Bands
   Erasers Containing latex Condoms or diaphragms

EXEMPLAR ALLERGY & ASTHMA OFFICE PATIENT POLIIES

Welcome to our office. We are pleased that you have chosen Exemplar for your medical care. In order for us to provide the quality care that you expect in an efficient manner, we must insist that you read and comply with the following policies.

1. We require reasonable notification (24 hours when possible) of cancellation or rescheduling of all appointments. If three (3) appointments are missed without notification, we will, unfortunately have to terminate our patient relationship.

2. All insurance cards (including Medicaid) need to be available at the time of each appointment. If there is no insurance card available at the time of your appointment, you will be asked to reschedule for another day and time.

3. If you arrive over 15 minutes late for your appointment, the appointment will have to be rescheduled.

4. If you (the patient) are 17 years old or younger, you must be accompanied by a parent or legal guardian. A Consent Form signed by a parent or legal guardian is required if the under-18 y/o patient is accompanied by another adult. This is a legal requirement and no exceptions will be made. (Consent form required.)

5. If you do not have insurance and are paying with a check or debit/credit card, you need to pay a minimum of half of the total charges at the time of each visit. The remainder will be due in 30 days.

6. Exemplar offices operate on cash-less basis. We accept VISA, MASTERCARD, AMEX and DISCOVER (credit or debit card) with proper identification. CASH will only be accepted by the Office Manager or if other arrangements have been made.

7. Authorizations (from your insurance company), if necessary, are also your responsibility and are required on the date of service. Please contact your primary care physician or insurance company with any questions. All co-pays, co-insurance, and deductibles are due in full at your appointment. For questions concerning billing you may contact our billing office: AMBS (Blue Team) at (800) 294-7001 or (304) 363-7000.

8. By signing below you authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Administration or its intermediaries or carriers, or to the billing agent of the physician, any information needed for this or related claim. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits either to myself or the part who accepts assignment.

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____

Consent for Child less than 18 years old to be seen in the Allergy Clinic. If accompanied by someone other than parent/guardian.

I _____, (Parent or legal guardian) give

_____ Permission to have minor child less than 18

Years old _____ (Patient's name) seen and given

Medical care by Exemplar Inc. (AKA, Exemplar Allergy) providers. I can be reached at the following number

_____ in case of an emergency.

_____

Parent or Legal Guardian Name (printed)

_____ _____

Parent or Legal Guardian Signature Date

_____ _____

Witness Signature Date