



NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

TEXAS HEALTH RESOURCES DALLAS

Professional Building 2
8220 Walnut Hill Lane, Suite 101
Dallas, TX 75231
Tel: (214) 369-1901

BAYLOR PLANO

Pavilion 1
4708 Alliance Blvd, Suite 610
Plano, TX 75093
Tel: (972) 596-4383

Fax: (214) 369-1905

Web: www.texasallergyonline.com

REGISTRATION FORM (Please print as clearly as possible, Thanks!)

Date: _____ Name: _____

How did you hear about us: _____ E-mail: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

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

Employer: _____ Occupation: _____

Date of Birth: _____ Age: _____ Social Security #: _____ Marital Status: S M W D

EMERGENCY CONTACT:

Name: _____ Relationship: _____

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

INSURANCE POLICY HOLDER (if different from above):

Name: _____ Relationship: _____

Address: _____

Employer: _____ Date of Birth: _____ Social Security #: _____

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

ASSIGNMENT OF BENEFITS: I hereby authorize the staff of North Texas Allergy & Asthma Associates to release any information required to process this claim and claims for any future treatment unless rescinded by me in writing. I authorize payment of medical benefits to North Texas Allergy & Asthma Associates for services performed. I also understand that any and all services (including allergy extract) that are not covered by the insurance will be my responsibility.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I understand that as part of my healthcare, North Texas Allergy & Asthma Associates originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and in other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals and as required or permitted by law without my consent.

The Physician's Notice of Privacy Practices provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the Notice of Privacy Practices and understand that I have the right to review the notice prior to signing this acknowledgement. I understand that North Texas Allergy & Asthma Associates reserves the right to change the Notice of Privacy Practices. Prior to implementation of a revised Notice of Privacy Practices, the revised Notice will be made available to me.

I have been provided and have reviewed the Notice of Privacy Practices dated April 14, 2003.

MEDICAL RECORD AND INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION RELEASE: I authorize North Texas Allergy & Asthma Associates to release my medical information and/or individually identifiable health information to me, my duly authorized representative (as noted below), representatives of local, state, or federal agencies and insurance companies or other organizations or entities as may be required or permitted under federal or state law or as may be required for review or payment of claims. I further authorize North Texas Allergy & Asthma Associates to release such information to physicians, hospital, or healthcare providers needing such information to treat me or to review my treatment. I understand that the specific information to be released may include, but is not limited to, history diagnosis and/or treatment of drug or alcohol abuse, mental illness or communicable disease. I also understand that this authorization may be revoked by me by a written and dated notice, except to the extent that disclosure of information has been made prior or receipt of such revocation. I authorize the use of a copy of this release and consent in place of the original.

I acknowledge that I have read and understand the contents of this registration form and release information and that my signature below indicates that I have completed the form accurately and to the best of my ability.

Date: _____

Name: _____

Patient Signature: _____

If a minor, authorized representative of Patient:

Relationship: _____

Name: _____

Signature: _____

PLEASE ALLOW US TO MAKE COPIES OF YOUR INSURANCE CARD (S).



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DISCLOSURE AND INFORMED CONSENT MEDICAL & DIAGNOSTIC PROCEDURES

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used, so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedures recommended to you.

I (we) voluntarily request North Texas Allergy & Asthma Associates staff physicians, and such associates, and other health care providers as they may deem necessary, treat my conditions involving any organ system of the body, but primarily nasal allergy, eye allergies, asthma, eczema, urticaria, angioedema, headaches, and gastrointestinal symptoms.

I (we) understand that the following medical and/or diagnostic procedures may be necessary for me, and I (we) voluntarily consent and authorize these procedures as deemed necessary upon examination:

- | | |
|--|---|
| 1) Skin testing (Percutaneous and Intradermal) | 5) Tympanogram |
| 2) Patch tests | 6) Blood studies |
| 3) Immunizations | 7) Radiology (cat scans and x-rays) |
| 4) Pulmonary function test | 8) Rhinopharyngolaryngoscopy (rhinoscopy) |

I (we) understand that my physician may discover other or different conditions, which may require additional or different procedures than those planned. I (we) realize that common to medical and/or diagnostic procedures is the potential for infection, hemorrhage, syncope, allergic reactions, and in very rare instances, even death due to severe systemic reaction. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures, which are advisable in their professional judgment. I (we) understand that no warranty or guarantee has been made to me as to the result of any procedure or cure of any condition.

Just as there may be risks and hazards in continuing my present condition, with or without treatment or procedure(s), there are also risks and hazards related to the performance of the medical and/or diagnostic procedures, which may be planned for me.

For example: I (we) understand that immunotherapy may result in complications of anaphylaxis and even death. The American Academy of Allergy, Asthma, and Immunology recommends that immunotherapy be given under a physician's supervision. This practice believes this position is medically appropriate and that you should always obtain your injection by trained personnel, either in our office or another medical setting. Thus, I (we) understand that the immunotherapy is to be administered under a physician's supervision. Furthermore, I (we) understand that it is required for me to wait in the waiting room **AT LEAST 20 MINUTES** after each allergy injection. If I (we) leave early, I (we) understand that it is against medical advice and will hold my treating physician and staff at North Tx Allergy & Asthma Associates free of any liability.

I (we) understand that anesthesia (used only with rhinoscopy) involves the additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us). I (we) understand that certain complications may result from the use of any anesthetic, including respiratory problems, drug reactions, paralysis, brain damage or even death.

I (we) have been given an opportunity to ask questions about my condition and treatment, alternative forms of anesthesia (used only with rhinoscopy) and treatment risks or non-treatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that (we) have sufficient information to give this informed consent. I (we) acknowledge that this disclosure and informed consent has been fully explained to me, that I (we) have read it or have had it read to me and that I (we) understand its contents.

Patient Signature: _____

If minor, Name of Legal Guardian: _____

Patient Name: _____

Signature of Legal Guardian: _____

Date: _____

Address: _____

NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

Date:

Physicians
Primary care doctor: _____
Specialist MD: _____
Specialist MD: _____
Specialist MD: _____

(Please be sure to complete reverse)

Name:

Current Medical Diagnosis
<input type="checkbox"/> Heart attack
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Liver disease
<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Acid reflux disease
<input type="checkbox"/> Other _____

Eyes
<input type="checkbox"/> Eye surgery
<input type="checkbox"/> Cataract
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Blurred vision
<input type="checkbox"/> Double vision
<input type="checkbox"/> Eye pain
<input type="checkbox"/> Infection of eyelashes or lids

Endocrine
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Frequent thirst
<input type="checkbox"/> Heat intolerance
<input type="checkbox"/> Cold intolerance
<input type="checkbox"/> Easily fatigued

Surgical History (include year)
<input type="checkbox"/> Eye surgery
<input type="checkbox"/> Sinus surgery
<input type="checkbox"/> Ear surgery
<input type="checkbox"/> Removal of tonsils
<input type="checkbox"/> Removal of adenoids
<input type="checkbox"/> Removal of appendix
<input type="checkbox"/> Removal of gall bladder
<input type="checkbox"/> Other _____

Gastrointestinal
<input type="checkbox"/> Loss of Appetite
<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation
<input type="checkbox"/> Vomiting blood
<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Heartburn
<input type="checkbox"/> GERD
<input type="checkbox"/> Ulcer
<input type="checkbox"/> Hiatal hernia
<input type="checkbox"/> Inflammatory Bowel Disease
<input type="checkbox"/> Irritable Bowel Syndromes (IBS)

Lung & Chest
<input type="checkbox"/> COPD
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Chronic Bronchitis

General
<input type="checkbox"/> Fever
<input type="checkbox"/> Chills
<input type="checkbox"/> Weight Gain/Loss

Skin
<input type="checkbox"/> Hives
<input type="checkbox"/> Rash
<input type="checkbox"/> Eczema
<input type="checkbox"/> Skin cancer
<input type="checkbox"/> Psoriasis

Neurological
<input type="checkbox"/> Migraine
<input type="checkbox"/> Headaches
<input type="checkbox"/> Frequent dizzy spells
<input type="checkbox"/> Lightheaded
<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Tremor/hand shaking
<input type="checkbox"/> Stroke
<input type="checkbox"/> Numbness or Tingling
<input type="checkbox"/> Weakness

Ears, Nose, and Throat
<input type="checkbox"/> Frequent ear infections
<input type="checkbox"/> Ringing in the ear
<input type="checkbox"/> Ear surgery
<input type="checkbox"/> Ear tubes
<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Dizzy spells
<input type="checkbox"/> Snoring
<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Frequent sore throats
<input type="checkbox"/> Trouble swallowing

Heart
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Heart palpitations
<input type="checkbox"/> Irregular pulse
<input type="checkbox"/> Heart attack
<input type="checkbox"/> Pacemaker

Hematologic
<input type="checkbox"/> Easily bruised or bleed
<input type="checkbox"/> Anemia
<input type="checkbox"/> Blood clots
<input type="checkbox"/> Blood transfusion
<input type="checkbox"/> Swollen glands

Cancer
<input type="checkbox"/> Type _____

Musculoskeletal
<input type="checkbox"/> Joint pain
<input type="checkbox"/> Joint stiffness
<input type="checkbox"/> Weakness of muscles/joints
<input type="checkbox"/> Muscle pain or cramps
<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Other arthritis syndromes
<input type="checkbox"/> Gout
<input type="checkbox"/> Sciatica
<input type="checkbox"/> Frequent neck pain
<input type="checkbox"/> Frequent back pain
<input type="checkbox"/> Osteoporosis

Psychiatric
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Memory loss
<input type="checkbox"/> Moodiness

For Women Only
<input type="checkbox"/> Are you currently pregnant
<input type="checkbox"/> Planning pregnancy in the future

Smoking History
Do you smoke? _____
If yes - what do you smoke: _____
How many years: _____
How many packs per day: _____
Exposed to 2nd hand smoke?: _____

Alcohol Use
Do you drink alcohol? _____
If yes - what kind: _____
How many times a day? _____

Illicit Drug Use
Do you take any illegal drugs? _____
If yes - what kind: _____
How did you use? _____

Family History

	Mother	Father	Brother (s)	Sister (s)	Maternal Grandparents	Paternal Grandparents	Son (s)	Daughters (s)	
Allergies									Any genetic disorders:
Asthma									
Eczema									
Sinus Problems									
Hives									
Food Allergies									Please expand below if needed for any problems identified
Thyroid Disease									
COPD									
Immunodeficiency									
Heart disease/heart attack									
Stroke									
Auto-immune Disease									
Cancer (indicate type)									

Environmental History

Animal Exposure	Type of home:	Type of A/C:
Do you have any pets? _____	Years in current home: <input type="checkbox"/> Home <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile home <input type="checkbox"/> Farm	<input type="checkbox"/> Central <input type="checkbox"/> Window <input type="checkbox"/> Cooler
Number of cats: <input type="checkbox"/> Sleep indoors <input type="checkbox"/> Sleep outdoors	Type of pillows: Do you have pillow covers? <input type="checkbox"/> Feather/Down <input type="checkbox"/> Polyester <input type="checkbox"/> Foam	Type of heating: <input type="checkbox"/> Oil/gas <input type="checkbox"/> Electric <input type="checkbox"/> Coal <input type="checkbox"/> Gas fireplace <input type="checkbox"/> Wood fireplace <input type="checkbox"/> Wood stove
Number of dogs: <input type="checkbox"/> Sleep indoors <input type="checkbox"/> Sleep outdoors	Number of birds: _____	Any of the following in your home? <input type="checkbox"/> Ceiling fans <input type="checkbox"/> Humidifier <input type="checkbox"/> Air filter <input type="checkbox"/> Stuffed animals <input type="checkbox"/> Bookcases
Number of gerbils/guinea pigs: _____	Mattress: Regarding your mattress: How old? _____ Mattress covers? _____	Other Are you sensitive to perfumes? What kind? _____ _____ _____
Number of horses: _____	Type of plants: <input type="checkbox"/> Live <input type="checkbox"/> Silk <input type="checkbox"/> Don't have	_____
Other animals: _____ _____	Type of flooring: <input type="checkbox"/> Carpeted <input type="checkbox"/> Hardwood <input type="checkbox"/> Tile <input type="checkbox"/> Vinyl	_____
Are you exposed to any animals at work? _____	_____	_____
What kind? _____ _____	_____	_____
Other: _____ _____	_____	_____