LAKESHORE ALLERGY PC

New Patient Information Sheet

PLEASE PRINT CLEARLY

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: (please circle) HOME or CELL

Home Phone: (___) _____ Cell Phone: (___) _____

Social Security #: _____

Married: _____ Single: _____ Divorced: _____ Separated: _____ Widowed: _____

E-Mail: _____

Primary Physician: _____

Referring Physician: _____

Emergency Contact: _____ Phone: (___) _____

Emergency Contact: _____ Phone: (___) _____

Parents' Names if Patient Under 18:

Mother: _____ Father: _____

Subscriber and Insurance Information

Primary Insurance: _____ Effective Date: _____ Copay: _____
Subscriber Info:

Name: _____ Date of Birth: _____ Phone: (___) _____

Social Security #: _____ Employer: _____

Insurance ID: _____ Group: _____

Secondary Insurance: _____ Effective Date: _____ Copay: _____
Subscriber Info:

Name: _____ Date of Birth: _____ Phone: (___) _____

Social Security #: _____ Employer: _____

Insurance ID: _____ Group: _____

*Name:*_____ *Date of Birth:* _____

Race: (please circle)

American Indian/Alaska Native | Asian | Black/African American

Hispanic or Latino | Native Hawaiian | Other Pacific Islander

White (not Hispanic or Latino) | More than one race

Unreported/Refused to report

Ethnicity: (please circle)

Hispanic or Latino | Not Hispanic or Latino | Unreported/Refused to report

Language: (please circle)

English | Chinese | Spanish | French | Italian | German | Hindi

Declined | Other: _____

LAKESHORE ALLERGY PC

New Patient Questionnaire

(This information is needed prior to your appointment)

Name:_____ **Date of Birth:** _____ **Date of Visit:** _____

Primary Care Physician: _____

Please list any other doctor you would like a letter sent to: _____

Previous Exams: (please circle if applicable) These reports are helpful for your visit, please fax to our office at (616) 738-4266.

Previous Allergist	Chest X-Ray	Pulmonary Function Test	EGD
Prior Allergy Testing	CT of Chest	CT of Sinuses	Biopsy: _____

Past Medical History: (please circle if past or present condition)

CANCER
- Bone
- Breast
- Cervical
- Colon
- Liver
- Lung
- Lymphoma
- Ovarian
- Pancreatic
- Prostate
- Skin
- Thyroid
- Other: _____

RHEUMATOLOGICAL
- Chronic Arthritis
- Fibromyalgia
- Lupus
- Psoriatic Arthritis
- Rheumatoid Arthritis
- Other: _____

GENITOURINARY
- Kidney Disease
- Kidney Stones
- Urinary Tract Infection
- Other: _____

GENETIC/DISORDERS
- Autism
- Cerebral Palsy
- Cystic Fibrosis
- Down Syndrome
- Other: _____

SKIN
- Eczema
- Hives
- Psoriasis
- Rash
- Other: _____

LUNG
- Asthma
- Chronic Bronchitis
- Chronic Cough
- COPD
- Emphysema
- Pneumonia
- Pulmonary Embolism
- Pulmonary Fibrosis
- Pulmonary Nodule
- Sleep Apnea
- Sarcoidosis
- Tuberculosis
- Other: _____

GASTROINTESTIONAL
- Celiac Disease
- Chronic Gastritis
- Crohn's Disease
- Colon Polyps
- Diverticulitis
- Heartburn / Reflux
- Irritable Bowel Syndrome
- Other: _____

HEAD AND NECK
- Allergies (Hay Fever)
- Deviated Septum
- Ear Infections
- Headaches
- Migraine Headaches
- Nasal Polyps
- Sinusitis
- Sore Throat
- Strep Throat
- Other: _____

HEART DISEASE
- Arrhythmia
- Congestive Heart Failure
- Coronary Artery Disease
- Heart Attack
- High Cholesterol
- Hypertension (High Blood Pressure)
- Hypotension (Low Blood Pressure)
- Mitral Valve Prolapse
- Stroke / Transient Ischemic Attack (TIA)
- Other: _____

ENDOCRINE
- Cirrhosis
- Diabetes
- Hepatitis A / B / C
- HIV
- Hypoglycemia
- Hypothyroidism
- Hyperthyroidism
- Other: _____

PSYCHOLOGICAL
- Anxiety
- ADD / ADHD
- Bipolar Disorder
- Depression
- Other: _____

Past Surgical History: (please circle if applicable)

ABDOMINAL
- Appendectomy
- Bowel Resection
- Cholecystectomy (Gall Bladder)
- Hysterectomy
- Hernia Repair: _____
- Other: _____

HEAD AND NECK
- Adenoidectomy
- Cataract removal
- Laser Eye Surgery
- Lymph Node Removal
- Myringotomy Tubes (Ear Tubes)
- Nasal Polyp Removal
- Sinus Surgery
- Tonsillectomy
- Thyroidectomy (or Partial)
- Other:

CORONARY/VASCULAR
- Coronary Artery Bypass
- Coronary Stent
- Pacemaker
- Valve Replacement
- Other: _____

OTHER
- Hip Replacement
- Knee Replacement
- Mastectomy
- Other: _____

Name: _____ ***Date of Birth:*** _____

Current Medications:

Please list any medications that you are taking with the dose and how often it is taken.

	Medication	Dosage	How Often/Frequency
1.			
2.			
3.			
4.			
5.			

Any Additional Meds: _____

Allergies:

Any Allergies to Medications or Foods? Yes / No

If yes, please list the Medications or Foods and what happens with each. (Example: Penicillin - Hives, Soy - Nausea, Vomiting)

	Medication/Food	Reaction		Medication/Food	Reaction
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Any Additional Allergies: _____

Family Medical History: **(Please check diagnoses and family member(s) that it applies to)**

			Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	*Paternal Grandfather*
DIAGNOSES:	**Mother**	**Father**	**MGM**	**MGF**	**PGM**	***PGF***
Drug Allergy						
Food Allergy						
Bee Allergy						
Asthma						
COPD						
Cystic Fibrosis						
Emphysema						
Sleep Apnea						
Tuberculosis						
Cancer						
Specify Type of Cancer						
Diabetes						
Thyroid Problems						
Specify Thyroid Problem						
Heart Attack						
Hypertension (High BP)						
Stroke						
Crohn's Disease						
Diverticulitis						
Heartburn/Reflux						
Lupus						
Psoriasis						
Rheumatoid Arthritis						
Bipolar Disorder						
Depression						
Other _____						

*Name:*_____ *Date of Birth:* _____

Travel History:

Any recent travel outside of the country? Yes / No

When: _____

Where: _____

Any illness related to that travel? Yes / No

What symptoms? _____

Environmental History: (please circle all that apply)

TYPE OF HOME
- Apartment
- Condominium
- Mobile Home
- Ranch
- Townhouse
- 2 Story
- Other: _____

AGE OF HOME
- less than 5 years
- 6-10 years
- 11-20 years
- 21-30 years
- 31-40 years
- 41-50 years
- More than 50 years
- Unknown

BASEMENT
- Finished
- Unfinished
- Damp or Wet
- Dry
- Crawl Space
- No Basement

HEATING
- Gas Heat
- Wood Heat
- Boiler Heat
- Electric Heat
- Other: _____

COOLING
- Central Air
- Window Air Conditioner
- No Air Conditioning
- Other: _____

AGE OF MATTRESS
- under 1 year
- 1-5 years
- 5-10 years
- Over 10 years
- Dust Mite Covers-Pillow
- Dust Mite Covers-Mattress
- No Dust Mite Covers

PETS INSIDE
- Cat
- Dog
- Bird
- Guinea Pig
- Hamster
- Reptile
- Other: _____

PETS OUTSIDE
- Cat
- Dog
- Horse
- Rabbit
- Other: _____

OCCUPATION (if student, list grade):_____

SETTING:
- Office
- Factory
- Outside
- Other _____

List any symptoms in the work place/school environment?

_____

_____

_____

SMOKING HISTORY

Have you ever smoked? Yes / No

If yes, how many per day? _____

What kind? _____

Year quit? _____

TOBACCO EXPOSURE

Past Exposure / Current Exposure / Never Exposed

If yes, specify: Work / Home / Childhood

LAKESHORE ALLERGY PC

Financial Policy

Insurance

Your insurance carrier will be billed according to our contract as a courtesy to you; however, payment for deductible and copay is due at the time of service. This includes all office visits, procedures, and injections. If you do not have your copay with you, your appointment may be rescheduled. Please remember that your insurance coverage is a contract between *you* and *your insurance company* and **NOT** a substitute for payment. Failure to provide us with your social security number may make it impossible for us to speak to your insurance regarding your claim.

Prior Authorizations

Some insurance companies require prior authorization for procedures done in the office. This will be the patient's responsibility to check with their insurance prior to their visit to avoid possible higher deductible and copay charges.

Self-Pay Accounts/Plans We Do Not Participate With

Self-pay accounts are patients that have no insurance coverage, have not met their deductible or are covered by insurance plans we do not participate with. Payment must be made at the time of service. If this is not possible, please discuss the situation with the billing department **before** your scheduled appointment.

No Show/Cancellation Policy

We kindly ask that you provide 24 hours notice if you are unable to keep a scheduled appointment. Failure to do so may result in a "no show/late cancellation" fee charged to your account. Payment of this fee will be required prior to the rescheduling of a new appointment. Multiple missed appointments may result in discharge from our practice. Exceptions will be made on a case by case basis. Thank you in advance for your cooperation.

Payment Methods

For your convenience, we accept the following methods of payment: cash, personal check, Visa, MasterCard, Discover, and American Express.

Authorization and Release

I authorize payment of medical benefits be made to Lakeshore Allergy PC. I understand the financial policy and accept the personal responsibility for payment of covered and non-covered services. I authorize the release of any medical or other information necessary to process my claims.

_____ _____

Printed Patient Name | Date of Birth

_____ _____

Signature of Patient or Person Completing this Form | Date

_____ _____

Printed Name of Person Completing this Form | Relationship to the Patient

Medicare Information/Authorization

Number: _____ Primary: (circle) Yes / No Medicare Part B: (circle) Yes / No

I request that payment of authorized Medicare benefits be made to Lakeshore Allergy PC. I authorize any holder of medical information about me needed to determine those benefits or the benefits payable for related services be released to the Health Care Financing Administration or its agents. I also authorize Medicare to send Explanation of Medicare Benefits information to my Medicare supplement plan for benefits to be paid to Lakeshore Allergy PC, for any services furnished to me until further notice.

_____ _____

Signature of Patient or Person Completing this Form | Date

Lakeshore Allergy PC –
Patient Consent for Use and Disclosure of PHI

The Patient hereby consents to the use or disclosure of personally identifiable information (also referred to as protected health information or PHI) and patient medical record / billing information by Lakeshore Allergy PC in order to carry out treatment, payment and healthcare operations. The Patient should review our Notice of Privacy Practices (NPP) for a more complete description of the potential uses and disclosures of such information, the Patient has a right to review this document prior to signing this consent.

This Organization has the right to change the Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed the Patient has a right to obtain a copy of the revised Notice.

Patient acknowledges and agrees that this Organization may disclose the Patient's protected health information and/or medical record - billing information to the following individual(s) who are the Patient's family members, guardians, legal representatives, healthcare surrogates or have power of attorney on behalf of the patient.

Name	Relationship	Phone

The Patient agrees that this Organization may disclose the following types of information if contained in the Patient's medical - billing records (**please initial** the appropriate categories):

____ HIV / AIDS Information

____ Mental Health Information

____ Substance Abuse Information

____ Sexually Transmitted Disease Information

____ Pregnancy Information (if Patient under Age 18)

This Organization will utilize the patients address and telephone numbers for communications unless an alternate form of communication is requested **(please initial** and complete appropriate items below):

____ E-mail (if this form of communication is offered by this Organization)

Fill in appropriate e-mail address: _____

____ Regular mail with any envelopes marked personal and confidential

____ Via other telephone number _____ _____

At all times the patient has the right to revoke this Consent by submitting the revocation in writing. The revocation shall be effective except to the extent that this Organization has already taken action in reliance upon this Consent.

This Organization may refuse to treat the Patient if he/she (or authorized representative) does not sign this Consent form. This Organization has the right to refuse further treatment after the time this Consent is revoked (except to the extent this Organization is required to provide treatment under the law).

This Organization has published a HIPAA 'Notice of Privacy Practices' (NPP). I have been informed and provided a copy of the NPP. **Please check one item below**:

____ NPP Provided

____ NPP Previously Provided

____ NPP Declined

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEVIED A COPY OF THIS CONSENT, AND AM THE PATIENT OR AUTHORIZED TO ACT ON THEIR BEHALF TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Print Patient Name: _____

Patient or Legally Authorized Representative Signature: _____

Relationship to Patient If Signed by Another Party: _____

Date: _____

LAKESHORE ALLERGY, PC

Office Policy

Billing Information

Patients are required to pay off any balance on their account **in 2 weeks**. **If longer than 30 days, interest will be added at 8%.**

Immunotherapy patients: serum and injection charges will be billed with every injection.

If you have a **copay, it is due at the time of service for all office visits. Deductibles are also due at the time of service.** Please check with your insurance company as to what your copay, deductible, and coinsurance are. If you do not pay your portion (copay/deductible/coinsurance), your insurance company can choose to make all the charges for the entire visit as your responsibility. Should your insurance change, it is your responsibility to notify us and know coverage for your services may change.

Please notify us of any insurance changes so we can correctly bill your medical claims. We will also ask to see your driver's license to protect you from identity theft.

No Show/Late Cancellations

If you need to cancel your appointment, you need to let us know **at least 24 HOURS** before your scheduled appointment. If you fail to do so, there may be a no show or late cancellation fee of $50.00 for new patient appointments and $25.00 for established patients. We have an automated appointment reminder that will leave a verbal phone reminder on your home phone or cell phone. It is your responsibility to provide us with your current phone number.

Forms

If you need forms filled out, there may be a charge of $10.00 for school forms and $25.00 for FMLA forms or any letter that Lakeshore Allergy PC needs to draft. If you need copies of records from our office, there may be a charge of $0.10 per page.

Injection Information

Please be here at least **40 MINUTES BEFORE CLOSING** and **WAIT 30 MINUTES** after your injection. You cannot leave until a nurse or the doctor has checked your arms.

YOU NEED TO MAKE AN APPOINTMENT WITH DR. HUTSON IF: your current medications are not working, you have new or worsening chest symptoms, you have had a local reaction to your injection the size of a fifty cent piece or larger, you have not had your injections for 6 weeks, or you have had a systemic reaction.

Be sure to update the nurses on any changes in medications, health history, etc. before receiving your injections.

If you have a long drive to the office, you may call before leaving to verify that Dr. Hutson has not had to leave due to unexpected circumstances, which rarely occurs.

NO FOOD OR DRINKS are allowed in the office due to other patients having food allergies.

Please do not wear perfumes or fragrances in the office as these affect our patients. Shoes and proper attire are required in our office.

We do not have a public restroom in our office, so please use the one located at the end of the hall BEFORE getting your injection.

PLEASE REFRAIN FROM USING YOUR CELL PHONE IN THE OFFICE/LOBBY. IF YOU NEED TO USE YOUR CELL PHONE, PLEASE STEP INTO THE HALL, BUT DO NOT LEAVE THE BUILDING.

Consent from a parent or legal guardian is required in order for others to bring a patient who is a minor to the office for injections or office visits- **NO EXCEPTIONS**. It is the parent's responsibility to sign a consent form and to let us know if they will not be bringing the minor in for treatment. Please request a form to complete.

_____ _____

Printed Name of Patient Date of Birth

_____ _____

Signature of Patient or Person Completing this Form Date

_____ _____

Printed Name of Person Completing this Form Relationship to the Patient

updated 2/2/2017

LAKESHORE ALLERGY PC

Beta-Blocker Screening

The medications listed below are "beta-blockers", commonly used to treat high blood pressure, angina (chest pain), irregular heart rhythms, migraine headaches and glaucoma. If you are presently on any of the medications listed below, place a check mark next to that particular medication.

	CAPSULES & TABLETS		Sectral (Acebutolol)
	Betachron (Propranolol)		Sorine (Sotalol)
	Betapace & Betapace AF (Sotalol)		Sotylize (Sotalol)
	Blocadren (Timolol)		Tenoretic (Atenolol)
	Brevibloc (Esmolol)		Tenormin (Atenolol)
	Gencaro (Bucindolol)		Timolide (Timolol)
	Bystolic (Nebivolol)		Toprol, Toprol XL (Metoprolol)
	Cartrol (Carteolol)		Trandate (Labetalol)
	Coreg, Coreg CR (Carvedilol)		Visken (Pindolol)
	Corzide (Nadolol)		Zebeta (Bisoprolol)
	Corgard (Nadolol)		Ziac (Bisoprolol)
	Hemangeol (Propranolol)		**EYE DROPS**
	Inderal, Inderal LA, XL (Propranolol)		Betaxon (levobetaxolol)
	Inderide, Inderide LA (Propranolol)		Betoptic (Betaxolol)
	Innopran XL (Propranolol)		Betagan (Levobunolol)
	Kerlone (Betaxolol)		Betimol (Timolol)
	Levatol (Penbutolol)		Cosopt (Timolol)
	Lopressor (Metoprolol)		Istalol (Timolol)
	Normodyne (Labetalol)		Ocupress (Carteolol)
	Normozide (Labetalol)		Optipranolol (Metipranolol)
	Pronol (Propranolol)		Timoptic (Timolol)

If you are started on any new medication(s) by your physician, please notify either our nurses or the physician in the office of any changes.

_____"I am presently **NOT** on any of the medications listed above."

_____ _____

Printed Name of Patient Date of Birth

_____ _____

Signature of Patient or Person Completing this Form Date

_____ _____

Printed Name of Person Completing this Form Relationship to the Patient