Patient Information

How did you hear about us: _____

Name (First, Middle, Last):_____ **Date of Birth:** _____

Address:_____

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

Email:_____ **Phone Number:** _____

Occupation:_____

Emergency Contact:
Name:_____ **Relationship:**_____
Phone Number:_____

Past Medical History: *Please check the box for any that apply*

☐ Arthritis	☐ Hepatitis A	☐ Fusion	☐ Blood Clots
☐ Fainting Attacks	☐ Hepatitis B	☐ Joint Replacement	☐ Chemical Exposure
☐ Fibromyalgia	☐ Hepatitis C	☐ Lupus	☐ Sciatica
☐ Neuropathy	☐ Gout	☐ Pinched Nerve	☐ Spider Veins
☐ Stroke/TIA	☐ Poor Circulation	☐ Varicose Veins	☐ Low Back Pain
☐ HIV	☐ Spinal Fractures	☐ Ulcers	☐ Poor Wound Healing
☐ Shingles	☐ Herniated Disc	☐ Bulging Disc	☐ Vitamin Deficiency
☐ Plantar Fasciitis	☐ Degenerative Disc	☐ Other: _____	

Primary Care Doctor (PCP) _____

Phone Number _____

List your prescribed medications and any over-the-counter medications, such as vitamins and inhalers.

_____
_____
_____
_____

List any Allergies

_____

_____

_____

Please check all that apply

Do you suffer from allergies? ☐ YES ☐ NO

If yes, which seasons: ☐ SPRING ☐ SUMMER ☐ FALL ☐ WINTER ☐ ALL YEAR

If yes, which of the following symptoms do you typically have:

☐ SNEEZING	☐ ITCHY AND/OR WATERY EYES	☐ SCRATCHY THROAT
☐ CONGESTION	☐ CHRONIC COUGH FATIGUE	☐ RESTLESSNESS
☐ POST NASAL DRIP	☐ JOINT PAIN	☐ ITCHY DRY SKIN
☐ HIVES	☐ RUNNY NOSE	☐ OTHER:_____

How long have you had these symptoms? ☐ Years ☐ Months

When do you typically experience them the most: ☐ Morning ☐ Afternoon ☐ Night ☐ All Day

Do you frequently get sinus infections, colds, flu or a runny nose? ☐ YES ☐ NO

Have you been diagnosed with Asthma? ☐ YES ☐ NO If yes, is it controlled? ☐ YES ☐ NO

Do you take any antihistamine medications to control these symptoms? ☐ YES ☐ NO If yes, please list them below & date last taken:

_____

_____

☐ YES ☐ NO Are you Pregnant? If no, are you planning on becoming pregnant within the next year? ☐ YES ☐ NO

☐ YES ☐ NO Are you HIV positive or have AIDS?

☐ YES ☐ NO Are you taking any Beta Blocker Medications? If yes, which one: _____

☐ YES ☐ NO Are you taking any Antibiotic Medications? If yes, which one: _____

☐ YES ☐ NO Do you have any Auto Immune Diseases? If yes, which one: _____

☐ YES ☐ NO Have you been Allergy Tested in the last 12 months? If yes, are you on immunotherapy? ☐ YES ☐ NO

☐ YES ☐ NO Are you planning on relocating within the next 12 months?

☐ YES ☐ NO Have you ever had a life-threatening allergic reaction and need emergency medical attention?

☐ YES ☐ NO Do you have Dermographism?

☐ YES ☐ NO Do you have any known food allergies? If yes, which one: _____

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS.

PATIENT NAME: _____ DATE: _____

In addition to the requirements of Virginia state law, the following consent is also intended to improve communication with and education of patients. The following has been explained to the patient or the person responsible for the patient:

1. The diagnosis requiring this procedure: Allergic Rhinitis.
2. The procedure is 95004 allergy prick tests, 86003 finger stick IgE blood test, and 95165 preparation of allergy therapy.
3. The nature of this procedure is: Hyposensitization - Injections or Sublingual.
4. The purpose of this procedure is: to alleviate allergic symptoms.
5. Possible risks: It is impossible to truly list all the complications that may occur from any procedure. However, risks here have been carefully considered. There may be possible risks involved in this procedure including but not limited to, skin rash, delayed response, diarrhea, allergic reaction, headache and arm reaction.
6. The likelihood of success of this procedure is excellent.
7. Immunotherapy is the primary course of treatment and will be mixed for you based on test results unless you decline.
8. The practical alternatives to this procedure include histamines and other medical treatments.

PROGNOSIS: If the patient chooses not to have the above procedure, the patient's prognosis (future medical condition) is unknown. I understand that the physician, medical personnel or other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition in recommending the procedure, which has been explained.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

I agree to allergy testing. Also, if treatment is needed, I agree to treatment as well.

Patient Name _____

Patient Signature _____ Date_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____Date: _____