NEW PATIENT HISTORY SHEET

I. PERSONAL DATA:

Name: ____ Birthdate: ________________

II. MAJOR ALLERGIC SYMPTOMS:

What type of allergy problems do you have? ____

How long have you had these problems? _____________________ How frequently? _________________________

Are you being treated for any other medical problems? ______________ If so, by whom? __________________________

What medications do you take and how frequently? ____

____

Have you ever been treated for allergies? _____________ Have you ever taken allergy shots? _________________

Have you ever had an allergic reaction to medicines/drugs? ____

If so, what type of reaction? ____

III. SYMPTOMS: PLEASE ANSWER ALL QUESTIONS!

Do you seem to have problems more in the:
Spring _______ Summer _______ Fall _______ Winter _______ All the time ________

Did your problems begin: Suddenly _______ Gradually _______

Are your problems worse in the: Morning _______ Afternoon _______ Night _______

Which parts of the body are more affected by your allergy symptoms/problems:
Head _______ Eyes _______ Nose _______ Ears _______ Chest _______ Skin _______ Intestinal _______

Are your symptoms affected by:
Dust _______ Pollens _______ Animals _______ Feathers _______ Mold/Mildew _______ Smoke _______
Time of Year _______ Air Conditioning _______ Strong Odors _______ Weather Changes _______
Foods/Diet _______

IV. FAMILY HISTORY:

Has anyone in your family had allergies, asthma, hay fever or sinus problems? Please check:
Mother _______ Father _______ Brothers/Sisters _______ Other Relatives (specify) _______________

Is there a history of any other serious medical problem/s? _______

If so, what? ____

ALLERGY & ASTHMA CENTER OF HILTON HEAD

First Name: ________________________ MI: _____ Last Name: ____

AKA (name you go by): __________________________

Parent/Guardian's Name (if minor): _____________________________________

Pt. Social Security Number: ______-_____-_______ Date of Birth: _________________ Gender: M F

Street Address: _______________________________ City/State/Zip: _____________________________________

Secondary Address: ____________________________ City/State/Zip______________________________________

Contact Numbers: Home: ____________________ Work: __________________ Cell: ______________________

Fax: ______________________ Email: ____

Race: _______________________________ Ethnicity: ____

Marital Status: Single_____ Married _____ Divorced _____ Widowed _____

Emergency Contact Person: ____ Phone: ____________________

Address (if different than patient) ____

Relationship: ________________________________

Employer: ____ Occupation: _______________

Drivers License - State/Number: ____

Referring Physician: ____

Primary Physician: ____

Pharmacy: ____

Insurance Company: ____

Policy Number: ______________________________________ Group Number: _______________________

Name on Policy: _____________________________________ Relationship: _________________________

Sponsor's Name: ______________________________________ Sponsor's Date of Birth: _______________

Sponsor's Social Security Number: ______-_____-_______

ALLERGY AND ASTHMA CENTER OF HILTON HEAD

FINANCIAL RESPONSIBILITY AGREEMENT

Payment is expected at the time of service. Payment may be made using cash, check or credit card (MasterCard or Visa). Any deductible, co-insurance or co-payment is payable prior to services rendered.

PAYMENT GUARANTEE: The undersigned agrees, whether signing as a patient or guarantor, to guarantee payment of the account in accordance with the standard rates and terms of The Allergy and Asthma Center of Hilton Head. I understand that my insurance, if any, is a contract between the insurance company, and myself except in certain cases when this office has a specific contract with an insurance company. I further understand that any balance remaining after insurance approves or denies payment is my responsibility to pay.

In the event the charges incurred are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney or both, I agree to be responsible for and pay, in addition to the charges for services and treatment received, all costs reasonably associated with such collection activity including but not limited to reasonable collection fees, skip tracing cost, court costs and attorney fees.

The Allergy and Asthma Center of Hilton Head may also check credit reports and report unpaid balances to credit bureaus. The Allergy and Asthma Center of Hilton Head reserves the right to transfer unpaid balances to outside entities for collection, such as banks or other financial institutions.

It is not customary for physician's to discuss the cost/s of medical procedures unless asked. If you want to know what the fee of a particular procedure is, please ask before the procedure is performed.

New Patients: If skin testing is performed, we may collect $250.00 to cover a portion of the cost of the test, especially if your annual deductible has not yet been met. By signing this form, you are verifying that you understand this may not cover the entire fee for tests performed.

THE UNDERSIGNED, HAVING READ AND UNDERSTOOD THE AGREEMENT, ACCEPTS THIS FINANCIAL RESPONSIBILITY AGREEMENT.

Patient Name (Printed): ____

Patient Signature: ____

Relationship to Patient: ____________________ Date: _______________________

ALLERGY AND ASTHMA CENTER OF HILTON HEAD
Thomas C. Beller, MD
60 Main Street, Suite D
Hilton Head Island, SC 29926
Phone: 843-689-6442 Fax: 843-689-6158

RELEASE INFORMATION

I hereby authorize The Allergy and Asthma Center of Hilton Head to release all medical information to all my insurance carriers, Medicare or the Social Security Administration, as may be required or requested for the processing of claims for insurance, social security, disability or Workers Compensation or for other insurance purposes.

I have read and understand the following forms:

1) HIPAA Notice of Privacy Practices
   We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number. (Initial _______)

2) Communications
   It is acceptable to leave messages regarding appointments and test results on my answering machine/voice mail and/or with a family member.
   (Initial _______)

My signature below is only acknowledgement that I have received the Allergy and Asthma Center's Notice of Privacy Practices.

Print Name: ___________________________________

Signature: ____________________________________

Relationship to patient: __________________________

Date: ____________________

TCB/ljsn
12/16

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Skin Test Scheduling Agreement

If Dr. Beller orders testing (skin or challenge), I understand that this appointment requires a significant amount of time to be blocked on the schedule of the Allergy & Asthma Center. If I am unable to keep this appointment for any reason, I agree to cancel it at least 24 hours in advance. I also agree to pay a **$50 cancellation/no-show fee** if I cancel the appointment within 24 hours of the scheduled time or if I do not show up for testing. I understand that this fee will not be covered by my insurance.

____________________________________ _________________________
(Signature) (Date)