NORTH TEXAS ALLERGY & ASTHMA CENTER

DENTON NORTH
2617 Scripture St.
Suite 101
Denton, TX 76201
Phone: (940) 382-4142
Fax: (940) 382-7620

DENTON SOUTH
3105 Colorado Blvd.
Suite 101
Denton, TX 76210
Phone: (940) 387-1700
Fax: (940) 382-7620

GAINESVILLE
1902 Hospital Blvd.
Suite C
Gainesville, TX 76240
Phone: (940) 382-4142
Fax: (940) 382-7620

Medical History

Name _____ Date of Birth _____ Date of Visit _____

Gender _____ Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language _____

Race(s) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

Primary Care Physician _____ City _____

Pharmacy _____ Location _____

How did you find out about our practice? _____

Reason for your visit _____

Current ongoing medical problems _____

Previous resolved medical problems _____

Past surgeries (include approximate date) _____

Current prescription, OTC and herbal medications (include dose/frequency) _____

_____

_____

Previous allergy and asthma medications tried (include oral medications, inhalers, nasal sprays and eye drops) _____

_____

Most effective allergy and asthma medications (from above) _____

Please list names and approximate dates of any antibiotics taken in last year _____

_____

Please list approximate dates of any oral steroids taken in last year_____

Please list any known allergies (chemicals, foods, insect stings, latex, medications, etc.) _____

_____

Are you up to date on your immunizations? _____ Have you had an adverse reaction to any vaccine? _____

Date of most recent flu vaccine (if any) _____ Date of most recent pneumonia vaccine (if any) _____

Please list any major infections requiring hospitalization _____

How many times have you had pneumonia? _____ Do you have a history of TB or TB exposure? _____

How many times have you had sinusitis or bronchitis in the last year? _____How many ear infections have you had in the last year? _____

Please list any allergy, asthma, immune or autoimmune problems in your family and the family member's relation to you _____

_____

Review of Systems: Please circle any symptoms you are currently experiencing below

Constitutional:	Fevers	Chills	Night sweats	Fatigue			
Eyes:	Vision changes	Itching	Tearing	Redness	Swelling		
ENT:	Drainage	Nose bleeds	Congestion	Sinus pain	Ear pain	Ear ringing	Sore throat
Respiratory:	Coughing	Wheezing	Tightness	Shortness of breath	Bloody sputum		
Cardiovascular:	Chest pain	Palpitations	Dizziness	Exercise intolerance			
Gastrointestinal:	Heartburn	Bloody stools	Vomiting	Diarrhea	Constipation	Abdominal pain	Cramping
Urinary:	Blood in urine	Painful urination	Difficulty urinating	Low back pain			
Neuro:	Headache	Seizures	Numbness	Weakness			
Hematology:	Unusual bleeding	Easy bruising	Swollen nodes				
Skin:	Hives	Eczema	Dry skin	Itching	Swelling		
Endocrine:	Weight loss	Weight gain	Cold intolerance				
Psychology:	Anxiety	Depression	Increased Stress				

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Patient Financial Advisory

Patient's Name _____

Date of Birth _____

Non-Covered Services

_____ (initials) I understand North Texas Allergy & Asthma Center (NTAAC)'s contractual agreement with health care service plans relates only to items and services which are deemed "covered" by the individual health plan. Consequently, I accept full financial responsibility and agree to pay out-of-pocket for all items or services which are deemed "non-covered" by the individual health plan.

HMO Referrals

_____ (initials) I understand that if my insurance company has designated a primary care physician (PCP), I am required to have prior authorization from my PCP prior to my office visit. If the authorization is not provided, whether by the Guarantor or through the insurance carrier, the Guarantor will be asked to reschedule the appointment or pay for the visit out-of-pocket at the time of service.

Self-Pay Accounts

_____ (initials) Self-pay accounts are (1) those with no available health insurance coverage at the time of service or (2) those that are covered by an insurance carrier with which NTAAC does not participate. I agree to be individually responsible to pay the full charges at the time of service if I have a self-pay account.

Changes to Coverage

_____ (initials) I understand that it is my responsibility to advise NTAAC of any changes with my insurance carrier, to confirm the practice's participation, and my eligibility prior to each visit. I agree to pay the full charges of all services rendered by NTAAC if services are deemed "non-covered."

Services Rendered

_____ (initials) I agree that in return for services provided to the patient by NTAAC, the account balance will be paid at the time service is rendered or I will make appropriate financial arrangements satisfactory to NTAAC for payment. If co-payments, deductibles or co-insurance amounts are designated by a contractual agreement to an insurance provider or health plan, I agree to pay these amounts to NTAAC. I understand and agree that if my account is delinquent, my account may be referred to a third-party agency for collections and fees may apply if such services are utilized. If extenuating circumstances should prevent me from providing payment, I may discuss the matter with the office manager.

- As a courtesy, NTAAC files claims to your insurance provider. If you are covered by insurance, it is your responsibility to understand the provisions under which you are covered.
- Missed or cancelled appointments with less than a 24 hour notice will be subject to a $25 no-show fee.
- A minimum fee of $25 may be assessed to release medical records.
- In the event that a guardian shares custody of a patient, the guardian present at the time of service is responsible for payment in full at that time. If you have a court order requiring treatment costs to be shared, it is the responsibility of the guardians to make appropriate arrangements prior to treatment.
- All returned checks will be assessed a $25 fee.

My signature below indicates I understand and agree to pay in full any balance unpaid by my insurance provider.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date
_____	_____	_____
Legal Representative's Printed Name	Legal Representative's Signature	Date

_____

If representative, specify relationship

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Consent for Use and Disclosure of Personal Health Information and Receipt of Notice of Privacy Practices

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information (PHI) to carry out treatment, payment activities, and healthcare operations (TPO).
Notice of Privacy Practices: Our office promises not to disclose your PHI (name, address, phone number(s), social security number, date of birth, etc.) outside of the TPO without your specific authorization and consent. Our office complies with HIPAA and all federal and state laws regarding the privacy of your information. A copy of our Notice of Privacy Practices document is available to you at any time at our office.
You may refuse to sign this authorization.
Acknowledged and agreed to by:

Patient or Parent Signature _____ Date _____

Patient Name _____
Patient DOB _____

Optional Disclosure of Protected Health Information
I understand that any and all medical care that I receive at North Texas Allergy & Asthma Center will be treated with the utmost confidentiality. To facilitate my medical care, I hereby authorize North Texas Allergy & Asthma Center to disclose PHI about my treatment and medical condition to the following individuals:

Name _____ Relationship _____

Date of Birth _____ Phone Number _____

Name _____ Relationship _____

Date of Birth _____ Phone Number _____

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Text, Voicemail and Email Authorization

Patient's Name _____ Date of Birth _____

We offer text and/or email messaging for appointment reminders and important announcements. By providing your cell phone number and email address below, you grant North Texas Allergy & Asthma Center permission to contact you regarding upcoming appointments and important announcements by text or email.
As part of routine patient care, it may be necessary to contact our patient(s) by telephone. In the event you are not available by phone, we may leave a detailed voicemail message regarding your/your child's treatment with your consent. By providing your telephone number(s) below, you grant North Texas Allergy & Asthma Center permission to leave detailed voicemail messages regarding your/your child's treatment.

My Cell Phone: _____ **My Email:** _____

Other Contact (name): _____ **Relationship to Patient:** _____

Cell Number: _____ **Email:** _____

Other Contact (name): _____ **Relationship to Patient:** _____

Phone Number: _____

Mark box below if you DO NOT wish to receive Text, voicemails and/or emails:

☐ I do not wish to receive voicemail messages regarding my/my child's treatment.

☐ I do not wish to receive texts regarding appointments or important announcements.

☐ I do not wish to receive emails regarding appointments or important announcements.

Please sign and Date Below to acknowledge the information above:

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date

_____	_____	_____
Legal Representative's Printed Name	Legal Representative's Signature	Date

_____

If representative, specify relationship