Allergy & Asthma Clinic
Of Northeast Georgia

New Patient Information

This information packet includes your pre-admission form and medical history questionnaire.

Please download, print and complete all pages, in their entirety and bring them with you to your appointment. This will expedite your admission and allow our doctors and staff to better serve you.

If you have any questions please contact our office at 770 534-0534.

Your Appointment: **Date:** _______________ **Time:** ____________

PATIENT INFORMATION:

NAME: Last:________________________ **First**:____________________ **Middle**:____________________

Preferred Name:__________________________ **Sex** F M **DOB**______/_______/________

EMail:____

Mailing Address:____

City: ____ **State**: _________ **Zip**:__________________

Home #: (_____)______-_________ **Cell** # (_____)______-_________ **Work #** (_____)______-_________

Marital Status: Single Married **Preferred contact #:** cell home work

Divorced Widowed **Student?** Yes No

Spouse's Name: ________________________________ **Spouse's Employer:** _________________________

Spouse's Contact #s: **Cell** # (______)________-___________ **Work #** (______)________-___________

Patient's Employer:__________________________________ **Occupation:** ___________________________

Employer Address:____

Patient's Primary Physician: ____

Referred by a physician?: Yes No **Referring Physician:** _______________________________

Names of Family Members that are Patients Here and Relationship to the Patient :

____

Emergency Contact:_______________________________ **Relationship to patient**: ___________________

Address:____ **Phone #:** (_____)________-___________

GUARANTOR INFORMATION: (the person responsible for payment that MUST sign paperwork)

Guarantor full name: ____ **DOB** _______/_______/________

Mailing Address (if different from patient): ____

____

Home #: (_____)______-_________ **Cell** # (_____)______-_________ **Work #** (_____) ______-_________

Social Security Number: _______________________ **Employer:** ________________________________

Employer Address: ____

Relationship to patient: SELF SPOUSE CHILD OTHER:_______________

INSURANCE INFORMATION: (please bring insurance card(s) to your appointment)

Insurance Company:____

ID/Policy #:____ **Group #:**__________________________

Insured's Full Name: ____

Insured's DOB: _______/______/________ **Insured's Social:**_____________________________________

MEDICAID or MEDICARE? Yes No **Policy #**____

Is there a secondary insurance? Yes No

Insurance Company:____

ID/Policy #:____ **Group #:**___________________________

Insured's Full Name: ____

Insured's DOB: ________/_______/_________ **Insured's Social:** _______________________________

PAYMENT IS EXPECTED AT TIME OF SERVICE for any amounts known to be not covered, or not paid by your insurance plan, including all co-pays and coinsurance amounts. We accept cash, check, Visa, MasterCard, Discover, American Express, and most FLEX/HSA spending cards. A fee of $35.00 will be charged for all returned checks.

If your insurance company does not respond within 30 days after your claim is filed, payment becomes your responsibility. Any amount due remaining after insurance has paid, or denied is expected to be paid upon receipt of your statement unless other arrangements are made with our billing department.

It is your responsibility to notify us of any changes to your insurance. If you do not, you are fully responsible for any amount not paid by the insurance company.

We are committed to providing our patients quality care. By informing you of our expectations, we hope to alleviate any misunderstandings concerning your financial responsibility. Should you have and questions about your account please call (770) 534-0534 and ask for our billing department.

I authorize release of any information necessary to process claims and direct payment to the Allergy & Asthma Clinic of Northeast Georgia. I understand that I am responsible for ALL charges, regardless of insurance coverage. IF THE PATIENT IS A MINOR, THE FINANCIAL RESPONSIBILTY LIES WITH THE PARENT/GUARDIAN BRINGING THE CHILD FOR TREATMENT.

____ ___________________

Guarantor Signature Date

How did you hear about us (circle one)? Physician Yellow Pages Website

Newspaper Family Member/Friend: ______________________ Other:___________________

Allergy & Asthma Clinic of Northeast Georgia

Michael J. Maloney, M.D. **Donell Ducote, FNP-C, CS** **John A. Yarbrough, M.D.**

Medical History Questionnaire

Patient Name: ____________________ Regular Physician: __________________________
Age: ___________ Problem to Discuss: ____
____

Symptoms: circle any chronic symptoms you have had.

HEAD AND NECK SYMPTOMS:

Runny nose **stuffy nose**

bouts of sneezing

itchy nose or throat or ear canals

post nasal drainage

frequent nosebleeds

sinus headaches **Other headaches**

any sinus infections?

itchy, watery eyes

popping in ears

hearing loss

bad taste in mouth or bad breath

medicines you have tried:
did they help?

CHEST & LUNG SYMPTOMS

shortness of breath

chest tightness

wheezing

"rattles in chest"

cough

sputum coughed up? ________ color? _________

Have you had asthma before?

Doctor's Notes
(Do not write in this column)

Medical History Questionnaire (page 2)

GASTROINTESTINAL SYMPTOMS

frequent vomiting or diarrhea

abdominal or stomach pain

heartburn or ulcer pain

poor appetite or excessive appetite

SKIN SYMPTOMS

eczema

hives

itching of skin

other rash? where? ________________

when? _________________

List ALL MEDICATIONS you are currently taking, whether or not they are prescription. (*includes aspirin, vitamins, herbs, etc.)*

Inhalants that you think make your most troublesome symptoms worse:

household dust feathers animal danders

mold mildew damp areas

tree pollens grass cuttings leaves hay

colognes or perfumes smoke

Other factors that increase your symptoms:

sunlight exercise fatigue

change in temperature or humidity

(Do not write in this column)

Medical History Questionnaire (page 3)

ENVIRONMENTAL HISTORY

(Do not write in this column)

Circle or fill-in the answers that apply to your home:

How long have you lived in your home? ______________________

It is made of: brick wood block Other: ________________

It is a: house / apartment / mobile home that is ______ years old

Type of mattress: foam / innerspring / water bed

Type of pillow: foam / feather / synthetic other:_____________
Pillow is _______ years old. Mattress is _______ years old.

Floors are mostly: carpet / wood / linoleum / other

House is generally: dry / dusty / moist / musty

Air conditioning is: central / window units / not installed

Heating system: electric / gas / oil / wood / kerosene

Basement is: damp / very wet / dry / do not have one

Change heat/air system filter every ________ months.

Any pets? Yes/no Type: ________________ Indoors? Yes/no

Any smokers in the home? Yes/no Who? __________________

How many people in household? _______________

Anything unusual or remarkable about this home? ____________

FOOD REACTIONS:

Describe any reactions to foods:

Are you on a special diet?

DRUG REACTIONS:

Describe any reactions to medications:

(i.e. penicillin, codeine, etc.) When did the reaction(s) occur?

Medical History Questionnaire (page 4)

INSECT ALLERGIES:

Describe any reaction to an insect sting and how it was treated:

(Do not write in this column)

PAST MEDICAL HISTORY:

Have you ever been seen by an allergist or an ear, nose and throat doctor? When?

Were you on allergy shots?

Any other health problems, hospitalizations, or chronic illnesses?

FAMILY HISTORY:

Describe allergic symptoms in family members: (i.e., hay fever, asthma, sinus problems)

Father:

Mother:

Brother:

Sister:

Sons:

Daughters:

SOCIAL HISTORY:

Occupation: ____

Work Environment: __________________________________

Tobacco use: _______________________________________

Hobbies? ____

___

ANY OTHER PROBLEMS TO DISCUSS?