



Patient _____ Age _____ Sex _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Home Phone Number _____ Social Security Number _____

Cell Phone Number _____ E-Mail _____

Could we send newsletters and other information to you from our practice by email? _____

Employed by _____ Address _____

Work Phone _____ Social Security number _____

Spouse (if adult)/Parent (if child) _____ D.O.B. _____ Driver License # _____

SS# _____ Marital Status (if child, parents marital status) _____

Employed By _____ Work Phone Number _____

Referring Doctor _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Method of Payment Cash/Check Visa/Mastercard Card # _____ Exp. Date _____

Signature _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY Effective Date _____

Insurance Company Name _____ Insured _____

Insurance Address _____ City _____ State _____ Zip Code _____

Insurance Phone _____ Insurance D.O.B. _____ Policy # _____ Group # _____

SECONDARY INSURANCE COMPANY Effective Date _____

Insurance Company Name _____ Insured _____

Patient name _____

Insurance Address _____ City _____ State _____ Zip Code _____

Insurance Phone _____ Insurance D.O.B. _____ Policy # _____ Group # _____

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (S) – BACK AND FRONT – AND ANY NEEDED AUTHORIZATION OR REFERRAL FORMS

I authorize the release of any medical information necessary to process any insurance claims. I also authorize payments of medical benefits **NATIONAL ALLERGY, ASTHMA & URTICARIA OF CHARLESTON, P.A.** I understand that I am financially responsible for all charges not covered by my insurance, irrespective of the amount of insurance coverage. I understand that my insurance coverage may not cover all my medical charges, and that I am responsible for any and all billing and/or collection fees.

Date _____ Signature _____

Witness _____

You are scheduled to visit us on _____ at _____ am/pm (circle one) for a complete allergy diagnostic examination. You should be prepared to be at the office at least 2-4 hours. **Take no antihistamines (Please see attached list of medications you need to stop) on the day of the examination and five (5) days before as these may interfere with the tests.**

The physicians and staff of the National, Allergy, Asthma & Urticaria Centers of Charleston are interested in providing excellent care to our patients. To provide that care, we need your cooperation. If you will not be keeping an appointment, we ask that you call our office and allow us to schedule another person in your place. This call should occur at least 48 hours prior to your appointment. Patients who have appointments and do not keep them deprive other patients of appointments or choice of an office location that may be better suited for their needs.

Therefore, we believe that keeping your appointment or a timely cancellation of the appointment of the appointment is an act of common courtesy.

Please obtain the following for your appointment:

1. Recent chest and sinus x-rays/cat scans if taken in the past year.
2. Recent allergy skin testing if done in the past 4 years
3. Recent allergy blood work in the past 4 years

Please complete the following outline and mail it to our office for review immediately. Try to answer the questions to the best of your ability. This information is very important in learning more about your allergy and how to control it.

How did you find about our practice? _____

Briefly state reason for an allergy consultation: _____

SYMPTOMS: Please check if you have any of the following problems:

- Asthma Food Allergy Hay Fever Hives Headaches Heartburn
 Recurrent infections Sinus problems Skin Allergy Reaction to insect Eye Allergies
 Other - Describe _____

PAST HISTORY :

What medical problems do you have? _____

Surgery (type & age when occurred) _____

Major infection or Illnesses (type & age when occurred) _____

Please describe any reactions to medications or latex _____

Have you had your flu vaccine (Please give date) ? _____ Pneumonia vaccine (Please give date)? _____

FAMILY HISTORY: Please list any allergies, asthma, or eczema in parents, brothers, sisters or children.

ENVIRONMENTAL HISTORY

Occupation & Hobbies _____

Do you have exposure to dogs, cats, birds, other animals or feather pillows in the home? Please describe. _____

Do you have carpet in your bedroom? _____ Do you ever sleep with the windows open? _____

Have you had any severe reactions to stinging insects or fire ants? Please describe. _____

Have you had any reactions to foods? Please describe. _____

Have you ever smoked? If so, Type, Amount and Age Begun: _____

Have you quit (Please list year you quit if applicable)? _____ Are you interested in quitting? _____

Who smokes in your household? _____

MEDICATIONS Please list all medications (over the counter, vitamins, herbs) and dosages
