ADVANCED allergy asthma sinus CARE

THE PALM BEACH CENTER for Facial Plastic & Laser Surgery

PATIENT INFORMATION AND AUTHORIZATION FORM

(PLEASE PRINT)

Date _____

Patient Name _____ ☐ Male ☐ Female
Last Name First Name Middle Initial

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell _____

SS# _____ Date of Birth _____ Age _____

☐ Single ☐ Married Spouse _____

Referred By _____ ☐ Primary Doctor ☐ Specialist ☐ Friend ☐ Family Member

Primary Physician _____ City _____ Phone _____
(If not referring as indicated above)

Emergency Contact _____ Phone Number _____

Email Address _____

RESPONSIBLE PARTY

Name (if different than patient) _____ Home Phone _____

Address (if different than patient) _____ Birth date _____

Place of Employment _____ SS# _____ Work Phone _____

INSURANCE INFORMATION

(PLEASE PROVIDE COPY OF INSURANCE CARD)

① PRIMARY INSURANCE COMPANY _____

Main Policy Holder _____ Birth date _____

SS# _____ Place of Employment _____ Relationship _____

②SECONDARY INSURANCE COMPANY _____

Main Policy Holder _____ Birth date _____

SS# _____ Place of Employment _____ Relationship _____

I, the undersigned, hereby authorize Advanced Allergy, Asthma and Sinus Care and/or The Palm Beach Center for Facial Plastic & Laser Surgery (PBC) to furnish my insurance company or any representative thereof with any and all information which may be requested regarding my past or present physical condition and treatment. I hearby authorize Advanced Allergy, Asthma and Sinus Care and/or PBC to administer such medical care as may be deemed advisable in the diagnosis and treatment of the patient. I further authorize my insurance company or any other parties to pay direct to Advanced Allergy, Asthma and Sinus Care and/or PBC my medical expenses payable under the terms of my contract.

_____ _____

Date Signature of Patient or **Responsible Party**

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ACKNOWLEDGMENT

I, _____ (patient), acknowledge that I have received a copy of Advanced Allergy, Asthma and Sinus Care and/or The Palm Beach Center for Facial Plastic & Laser Surgery's Notice Regarding Privacy of Personal Health Information.

_____
Date

_____
Patient Signature
(Responsible Party Signature if Patient is a Minor)

_____
Print Name

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DUE TO THE HIGH COST OF MEDICAL BILLING, PAYMENT IS REQUESTED AT THE TIME OF TREATMENT, UNLESS PAYMENT PLAN ARRANGEMENTS ARE MADE WITH THE DOCTOR OR THE OFFICE MANAGER. YOUR SIGNATURE INDICATED AGREEMENT WITH THE FOLLOWING STIPULATIONS:

1. Payment in full at the time of visit (if no insurance coverage). If your insurance plan indicates a co-payment by the patient, this must be paid at the time of the visit.

2. If payment for correctly filed claim is not received from your insurance company for any reason within 90 days, you will be responsible for the full amount due.

3. All costs including collection fees, court costs, and reasonable attorney fees will be insured by the signing party, if payment is not received as described above.

_____ _____

Date Signature

GREENWAY PROFESSIONAL CENTER III
4495 MILITARY TRAIL, SUITE 202
JUPITER, FLORIDA 33458
(561) 627-6277

VILLA FLORA
3658 SW 30TH AVENUE
PALM CITY, FLORIDA 34990
(772) 286-7490

ADVANCED
allergy
asthma
sinus
CARE

ADULT PATIENT EVALUATION

Name _____ Date _____

The main problem for coming here is: _____

PHYSICIAN'S NOTES

PLEASE COMPLETE EVERY BOX "YES" OR "NO"

NOSE			
Do your problems include:			**PHYSICIAN'S NOTES**
Runny Nose?	☐ Yes	☐ No	
Sneezing?	☐ Yes	☐ No	
Itchy Nose?	☐ Yes	☐ No	
Nasal Congestion?	☐ Yes	☐ No	
If *YES,* is there any pattern to this (for example time of day or year; exposure to dust, animals or smoke; other factors such as heat, cold, travel, etc.) OR no pattern at all (for example, constant, "comes and goes" with *no* pattern noted)?			
Do you use, or have you every used a nose spray?	☐ Yes	☐ No	
If YES: ☐ Prescription nose spray:			
Name _____			
Last used _____			
Did it help?	☐ Yes	☐ No	
☐ Over-the-Counter nose spray:			
Name _____			
Last used _____			
Did it help?	☐ Yes	☐ No	
Do you use, or have you ever used antihistamines and/or decongestants for nasal symptoms?	☐ Yes	☐ No	
If YES: ☐ Newer antihistamines such as Claritin, Allegra or Zyrtec?			
Name _____			
Last used _____			
Did it help?	☐ Yes	☐ No	
☐ Over-the-Counter older antihistamines and/or decongestants (ex: Benadryl)?			
Name _____			
Last used _____			
Did it help?	☐ Yes	☐ No	
Do antihistamines make you sleepy?	☐ Yes	☐ No	

EYES		
Do your problems include:		**PHYSICIAN'S NOTES**
Red eyes?	☐ Yes ☐ No	
Watery eyes?	☐ Yes ☐ No	
Itchy eyes?	☐ Yes ☐ No	
Puffy eyes?	☐ Yes ☐ No	
If *YES,* is there any pattern to this (for example time of day or year; exposure to dust, animals or smoke; other factors such as heat, cold, travel, etc.) OR no pattern at all (for example, constant, "comes and goes" with no pattern noted)?		
Do you use, or have you ever used, eye drops?	☐ Yes ☐ No	
If *YES*: ☐ Prescription eye drops:		
Name _____		
Last used _____		
Did it help?	☐ Yes ☐ No	
☐ Over-the-Counter eye drops:		
Name _____		
Last used _____		
Did it help?	☐ Yes ☐ No	

SINUS			
Have you ever been diagnosed as having sinusitis (a sinus infection)?	☐ Yes	☐ No	**PHYSICIAN'S NOTES**
Have you ever had a sinus CT Scan?	☐ Yes	☐ No	
If YES, were the results normal?	☐ Yes	☐ No	
Have you ever had a sinus x-ray?	☐ Yes	☐ No	
If YES, were the results normal?	☐ Yes	☐ No	
Do you have:			
Postnasal drip?	☐ Yes	☐ No	
Frequent headaches?	☐ Yes	☐ No	
Snoring?	☐ Yes	☐ No	
Previous Ear, Nose & Throat physician (if applicable) was Dr. _____			
History of sinus or nose surgery?	☐ Yes	☐ No	

ASTHMA			
Have you ever been diagnosed as having asthma?	☐ Yes	☐ No	
Do you have shortness of breath?	☐ Yes	☐ No	
Do you cough a lot?	☐ Yes	☐ No	
Have you ever had wheezing?	☐ Yes	☐ No	
Have you ever had a chest x-ray?	☐ Yes	☐ No	
Have you ever performed a pulmonary function test?	☐ Yes	☐ No	
Have you ever used an inhaler or nebulizer?	☐ Yes	☐ No	
If *YES*, name _____			
Date last used: _____			
Did it help?	☐ Yes	☐ No	

EARS		
		PHYSICIAN'S NOTES
Have you had frequent ear infections?	☐ Yes ☐ No	

SKIN		
Have you ever had skin allergies?	☐ Yes ☐ No	
If *YES*: ☐ Hives ☐ Eczema		

GI		
Have you ever been diagnosed as having gastroesophogeal reflux?	☐ Yes ☐ No	
Do you get heartburn?	☐ Yes ☐ No	

PAST MEDICAL HISTORY				
Any chronic health conditions (ex. Hypertension, diabetes, cancer):				
			since	
			since	
			since	
Past Hospitalizations:	Year		For	
	Year		For	
	Year		For	
Past Surgeries:	Year		For	
	Year		For	
	Year		For	
Past Emergency Visits:	Year		For	
	Year		For	

SMOKING HISTORY		
Are you or have you ever been a smoker?	☐ Yes ☐ No	
If so, how many years? Quit Date?		

PAST ALLERGY HISTORY	
Are you allergic to any (if *YES*, please list):	**PHYSICIAN'S NOTES**
Food ☐ Yes ☐ No	
Insect Venom ☐ Yes ☐ No	
Medicine ☐ Yes ☐ No	
Have you ever had allergy testing? ☐ Yes ☐ No	
If YES, testing was done by	
Dr._____ In _____ (month) (year)	
Have you ever received allergy shots? ☐ Yes ☐ No	
Still on allergy shots? ☐ Yes ☐ No	
Shots are received how often? _____	
Allergy shots have helped? ☐ Yes ☐ No	
Any minor reaction to shots? ☐ Yes ☐ No	
Any major reaction to shots? ☐ Yes ☐ No	
If severe reaction please explain:	

CURRENT MEDICAL STATUS			
Please list all current medications:	Dose	Times per Day	**PHYSICIAN'S NOTES**

CURRENT ENVIRONMENT						
Current occupation is: _____						
Do you live in a:						
☐ House ☐ Apartment ☐ Condominium ☐ Townhouse						
☐ Mobile Home ☐ Other						
Do you have:						
Cats	☐ Yes	☐ No	Cigarette smoke	☐ Yes	☐ No	
Dogs	☐ Yes	☐ No	Air conditioning	☐ Yes	☐ No	
Birds	☐ Yes	☐ No	Mold growth	☐ Yes	☐ No	
Other pets	☐ Yes	☐ No	Air cleaner	☐ Yes	☐ No	
If yes, please list			Ceiling fans	☐ Yes	☐ No	
			Curtains/Drapes	☐ Yes	☐ No	
Down comforter	☐ Yes	☐ No	Carpets or rugs	☐ Yes	☐ No	

FAMILY HISTORY					
	Allergies	Asthma	Frequent Cough	Frequent Infections	**PHYSICIAN'S NOTES**
Mother					
Father					
Brother(s)					
Sister(s)					
Grandmother(s)					
Grandfather(s)					
Uncle(s)					
Aunts(s)					
Cousin(s)					
Son(s)					
Daughter(s)					
Does your family history include chronic conditions such as cystic fibrosis, emphysema, recurrent hives or swelling, lupus, rheumatoid arthritis, etc.? (please list):					

REVIEW OF SYSTEMS (✓ if present and *NOT* already noted)		
Fever		
Weight loss		
Skin problems (other than eczema, hives)		
Joint swelling or pain		
Blood count problems (anemia, etc)		
Eye problems (explain)		
Throat infections		
Heart problems or high blood pressure		
Stomach upset		
Urinary or bladder problems		
Nerve or psychiatric problems		
Hormone problems (such as hot flashes, etc.)		