North Mississippi Allergy and Asthma Center, PLLC

Patient Information: Name: Last First MI (Legal Name)

Mailing Address:			County:
City:	State:	Zip:	Date of Birth
Social Security #:	Sex: M F		Marital Status: M S W D
Email Address:	Home Phone Number:		Cell Phone Number:
Disabled ☐ Retired ☐ Employed ☐	Employer:		Work Phone:
Emergency Contact:	Phone:		

How did you hear about us? ☐ Primary Care Provider Referral ☐ Specialist Provider Referral ☐ Patient Referral ☐ Hospital ☐ Insurance Company ☐ Internet Search ☐ Word of Mouth ☐ Advertising ☐ Other

Language:	English ☐	Spanish ☐	Japanese ☐	Other ☐	Unavailable ☐
Ethnicity:	Non Hispanic ☐	Hispanic ☐	Declined ☐	Unavailable ☐	
Race:	White ☐	Black/African American ☐	American Indian/ Alaska Native ☐	Asian ☐	
	Native Hawaiian/Other Pacific Islander ☐	Multiracial ☐	Declined ☐	Unavailable ☐	

Responsible Party Data (if other than patient): Name: Last First MI Relation to Patient:

Mailing Address:			
City:	State:	Zip:	Date of Birth
Social Security #:	Home Phone Number:		Cell Phone Number:
Employer:	Work Phone:		

INSURED'S INFORMATION: *Our goal is to file your insurance correctly; a front and back copy of your current card will help ensure this. If you do not have insurance, please check with the front desk regarding payment options that are available.*

Primary Insurance Name:	Secondary Insurance Name:
Primary Policy Holder ID#:	Secondary Policy Holder ID#:
Primary Insured's Social Security #:	Secondary Insured's Social Security #:
Primary Insured's Date of Birth:	Secondary Insured's Date of Birth:
Primary Insurance- Insured's Name:	Secondary Insurance- Insured's Name:

Disclosure of Personal Health Information:
North Mississippi Medical Clinics will not discuss your personal health information with anyone except those allowed under federal and state law without your authorization. Please list the names and relationships of those you authorize us to discuss your personal health information.

Contact Name	Relationship	Daytime Phone
Contact Name	Relationship	Daytime Phone
Contact Name	Relationship	Daytime Phone
Contact Name	Relationship	Daytime Phone

Patient/Guardian Signature: **Date:**

(form Revised March 2015) Form #975-008

Adult Form

NORTH MISSISSIPPI
ALLERGY & ASTHMA
CENTER

Medical History and Allergy Survey

Patient Name:_____**Age**_____ **Today's Date**_____

What are your expectations from today's visit:_____

_____

Circle the allergy problems that you have or would like evaluated:

Nasal Allergies	Asthma	Insect Allergy	Chronic Cough
Rash/Eczema	Sinus Problems	Drug Allergy	Food Allergy
Hives/Urticaria/Angioedema		Immune Work Up	

Review of Symptoms:
Please check if you have recently experienced any of the following:

Eye:	Ears:	Respiratory:	Skin:
___Dry	____Itching	___Shortness of Breath	____Itching
___Swelling	____Popping	___Wheeze	____Rash
___Itching	____Fullness	___Cough	____Hives
___Burning	____Hearing Loss	___Sputum	____Swelling

Nose:	Throat:	Immune:
___Sneezing	____Itching	____Recurrent Fever
___Runny Nose	____Soreness	____Recurrent Infections
___Mouth Breathing	____Post Nasal Drip	
___Itching	____Swelling	
___Nasal Obstruction		

Allergy:
Please answer if any applies:

Age of onset of allergies:_____
Allergies are: Seasonal Daily Year Round
Worst Months for your allergies:_____
Allergies are Stable or Worsening (circle one)
Known Triggers: (circle one)
Cat Dog Dust Smoke Fresh Cut Grass Pollen

Drug Allergies:_____
Food Allergies:_____

Any previous Allergy or Asthma Treatment:
Name of Allergist:_____
Have you ever received Allergy Shots: yes or no (circle one)
If yes, how long:_____

Medical History:

Current medical problems:_____
Surgeries? yes or no (circle one) If yes, _____
Have you ever been hospitalized for Asthma: yes or no (circle one)
Have you experienced?
recurrent sore throats, repeated sinus infections, or pneumonia? (circle one)
Are your vaccinations up to date? yes or no (circle one)
Do you receive a flu vaccine yearly? Yes or no (circle one)

Personal History for Pediatrics and Adults:

Attend Daycare or School:_____
Exposed to cigarette smoke: yes or no (circle one)
Do you live in a house, apartment, condo, or mobile home (circle one)
How old is the home: _____
Carpet: yes or no (circle one)
Indoor Pets or Outside Pets (circle one)
Air Conditioning: Central or Window Unit (circle one)
Pillow: Feather, Foam, or Polyester Fiber (circle one)
Bed: Regular or Feather (circle one)
Do you use a humidifier, air purifier, ceiling fans or fireplace? (circle all that applies)
Cockroaches or rodents: yes or no Mold or Mildew exposure: yes or no

Personal History for Adults only:

Do you smoke: yes or no (circle one) If yes, How many packs per day?_____
How many years have you smoked:_____
Do you drink alcohol? yes or no (circle one)
Do you use recreational drugs? yes or no (circle one)

Family History: List any immediate family member with allergy or asthma condition:

_____

North Mississippi Allergy and Asthma Center

Name of Patient:_____**DOB:**_____

I, THE UNDERSIGNED AGREE TO THE FOLLOWING:

I request that payment of authorized insurance and Medicare benefits be made on my behalf to NORTH MISSISSIPPI ALLERGY AND ASTHMA CENTER for any services rendered by Matthew L. Oswalt, MD or Karen Maltby, MD. I also authorize NMAAC to release medical information to my insurance for the purpose of substantiating payment for a claim.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize this clinic to release a copy of any and all protected health information they posses relative to my treatment to my insurance company. I further authorize the release of my protected health information concerning my illness and/or treatment to other physicians or facilities that are involved in my case.

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that I am financially responsible for all charges not covered by or not paid by my insurance company. If I do not have insurance, I take full responsibility for the payment of all charges.

DIVORECED PARENTS

Our office policy regarding a child of divorced parents is as follows: the parent who brings the child to the office for care by our physician is the party responsible for the doctor's fee. Any arrangement that must be made between the two parents concerning payment is the responsibility of the parents, NOT our office.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been given a copy of North MS Allergy and Asthma Center's Privacy Practices.

SCHOOL AUTHORIZATION RELEASE

I authorize the limited disclosure of health information regarding medication and emergency treatment to my child's school for said student and said authorization will remain in effect UNLESS revoked in writing.

_____

SIGNATURE OF PATIENT OR AUTHORIZED PERSON