

North Mississippi Allergy and Asthma Center, PLLC

Child Name:		Name: Last		First	MI	(Legal Name)		
Mailing Address:						County:		
City:		State:		Zip:		Date of Birth		
Social Security #:			Sex: M	F	Home Phone:		Cell Phone:	
Emergency Contact:				Phone:				
How did you hear about us? <input type="checkbox"/> Primary Care Provider Referral <input type="checkbox"/> Specialist Provider Referral <input type="checkbox"/> Patient Referral <input type="checkbox"/> Hospital <input type="checkbox"/> Insurance Company <input type="checkbox"/> Internet Search <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Advertising <input type="checkbox"/> Other								
Language:	English <input type="checkbox"/>	Spanish <input type="checkbox"/>	Japanese <input type="checkbox"/>	Other <input type="checkbox"/>	Unavailable <input type="checkbox"/>			
Ethnicity:	Non Hispanic <input type="checkbox"/>	Hispanic <input type="checkbox"/>	Declined <input type="checkbox"/>		Unavailable <input type="checkbox"/>			
Race:	White <input type="checkbox"/>	Black/African American <input type="checkbox"/>	American Indian/Alaska Native <input type="checkbox"/>		Asian <input type="checkbox"/>			
	Native Hawaiian/Other Pacific Islander <input type="checkbox"/>	Multiracial <input type="checkbox"/>	Declined <input type="checkbox"/>		Unavailable <input type="checkbox"/>			
Responsible Party Data (if other than patient):		Primary Custodial Parent: Last				First	MI	Date of Birth
Mailing Address:		City		State		Zip		
Social Security #:			Home Phone:		Cell Phone:			
Email Address:			Employer:		Work Phone:			
Other Parent: Last						First	MI	Date of Birth
Mailing Address (if different from above):		City		State		Zip		Contact Phone:
INSURED'S INFORMATION:								
<i>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.</i>								
Primary Insurance Name:				Insured's Date of Birth:				
Primary Policy Holder's Name:				Policy Holder ID#:				
Primary Insured's Social Security #:				Primary Insured's Employer:				
Secondary Insurance Name:				Insured's Date of Birth:				
Secondary Policy Holder's Name:				Policy Holder ID#:				
Secondary Insured's Social Security #:				Secondary Insured's Employer:				
Disclosure of Personal Health Information:								
<i>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.</i>								
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 #975-020

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: <input type="checkbox"/> Dry <input type="checkbox"/> Swelling <input type="checkbox"/> Itching <input type="checkbox"/> Burning	Ears: <input type="checkbox"/> Itching <input type="checkbox"/> Popping <input type="checkbox"/> Fullness <input type="checkbox"/> Hearing Loss	Respiratory: <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheeze <input type="checkbox"/> Cough <input type="checkbox"/> Sputum	Skin: <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Swelling
Nose: <input type="checkbox"/> Sneezing <input type="checkbox"/> Runny Nose <input type="checkbox"/> Mouth Breathing <input type="checkbox"/> Itching <input type="checkbox"/> Nasal Obstruction	Throat: <input type="checkbox"/> Itching <input type="checkbox"/> Soreness <input type="checkbox"/> Post Nasal Drip <input type="checkbox"/> Swelling	Immune: <input type="checkbox"/> Recurrent Fever <input type="checkbox"/> Recurrent Infections	

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 possess 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.

DIVORCED 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