



New Patient Registration

Physician Referred By: _____ Primary Care Physician (First & Last Name): _____

Reason for Visit: _____

Patient Information

Last: _____ First: _____ Middle Initial: _____ Date of Birth: _____

Gender: Male Female Other Marital Status: Married Single Widowed Divorced

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Email: _____

Required for access to our Patient Portal to request refills, make appointments, send messages to provider, schedule Telehealth appointment, etc

Employer: _____

Occupation: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Not required. For reporting purposes only

Race:

Asian Other: _____

Black or African American White

Declined to Specify

Ethnicity:

Declined to Specify Not Hispanic or Latino

Hispanic or Latino Other: _____

Emergency Contact Information

Name: _____ Relation: _____ Phone #: _____

Patient-Family Communication Authorization

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

I understand I have the right to revoke this authorization in writing at any time to the Practice Manager, except to the extent that action has been taken in reliance upon it. I hereby release and hold harmless Houston Pulmonary, Sleep & Allergy Associates, its physicians, staff, employees, agents, and any other persons involved, from any liability, damage or claim that may result from my authorization of the above communications.

Patient Name: _____ Signature: _____ Date: _____

Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Name: _____ Signature: _____ Date: _____

Updated Financial and Billing Policies

1. You are ultimately responsible for knowing what your insurance plan does and does not cover. This includes in-network/out-of-network benefits, out of pocket, co-payment, co-insurance, deductible, prior authorizations, referrals, etc.
2. Be prepared to show your photo identification and insurance card at every visit.
3. It is your responsibility to make certain that a valid referral is on file should your insurance require one. If there is not a valid referral on file at the time of service, we reserve the right to reschedule your appointment.
4. As a courtesy, we will verify your insurance benefits and eligibility. However, due to insurance policy changes and real-time/up-to-date system information, we cannot guarantee that the information received is accurate.
5. Once your benefits have been determined, payments of any co-pays, co-insurance, deductible, and fees are required at the time services are rendered.
6. Once your insurance company has processed a claim, any balance determined by your insurance company to be "patient's responsibility" and/or "non-covered service", will be your responsibility.
7. If you disagree with the "patient responsibility" amounts due to our office per your insurance's Explanation of Benefits (EOB), please immediately call your insurance company and our billing company, Revele (formally GroupOne), at 800-893-3557 for further explanation.
8. Failure to provide current insurance information to our office and/or reply to insurance's request for additional information may result in the entire bill being your responsibility.
9. Once a payment deemed patient responsibility has not been made on your account after three months, you may be sent to collection agency.
10. For Self-Pay patients, full payment for your visit and any testing (allergy testing, serum, allergy shots, pulmonary function test, spirometry, 6-minute walk, etc.) is expected at the time services are rendered.
11. Any outstanding balance owed to our office is also due, unless payment arrangements have been made in advance with our office.
12. Our office does not bill third parties (i.e.: automobile insurance). Your visit will be self-pay and a receipt will be given to you to file with your auto insurance. Our office does not accept workman's compensation cases.
13. Please notify us in advance if you cannot keep your appointment. We reserve the right to ask you to seek care from another physician if you miss three appointments without notification. If you are more than 30 minutes late for your appointment, you may be asked to reschedule.
14. A \$25 fee will be incurred if you do not cancel or reschedule your appointment with at least a 4-hour notice prior to the scheduled appointment time.
15. There will be a \$35 fee for all returned checks.
16. There will be a \$20 fee for paperwork completion, including but not limited to, FMLA, disability, life insurance, and school physicals. Payment is due prior to completion of the forms.
17. Fees for medical and billing records will be charged per the current allowable set by the Texas Medical Board. Payment is due prior to the processing of the request.

Updated Medication Refill Policies

1. Allow at least one week left on current medication when calling the pharmacy for a refill.
2. Allow at least 48 hours after we receive the refill request from the pharmacy to process the request.
3. Refills will not be processed as an "emergency". Please plan accordingly.
4. Patient is responsible for keeping track of the amount of medication remaining, and for taking the medication as prescribed.
5. No refills will be made during weekends or holidays.
6. Controlled substances require an appointment for every refill. There are no exceptions.
7. Triplicate prescriptions require an appointment every 3-6 months (or sooner if changes are needed).
8. All other maintenance medications require a 3-6 month follow up appointment for consideration on therapeutic regimen and necessary blood work.
9. It is per the discretion of the physician if an appointment will be required before a refill is granted. Many factors and circumstances are considered before a final decision is made.

By signing below, I acknowledge that I have read and understood all the above policy updates.

Patient Name (please print): _____

Date of Birth: _____

Signature: _____

Date: _____

Current Medications

NAME	DOSAGE	FREQUENCY	REASON

Date of Last Influenza Vaccination: _____

Date of Last Pneumonia Vaccination: _____

Past Medical History – Do you have a history of any of the following conditions? Check all that apply.

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hives | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pneumonia | |

Allergies to Medications/Foods/Environmentals

NAME	REACTION

Surgical History (Not Including Pregnancies)

NAME	PROCEDURE

Hospital Admissions (Not Including Pregnancies)

NAME	REASON FOR ADMISSION

Family History – If any relative listed below has suffered any of the following, please put a check in the box corresponding to the family member and the diagnosis.

FAMILY MEMBER	ASTHMA	HAY FEVER	SINUSITIS	HIVES	ECZEMA	CANCER	DIABETES	HTN	MIGRAINES
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandparents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Tobacco Use

Current Smoker When did you start smoking? _____

How many cigarettes a day do you smoke?

5 or less 6-10 11-20 21-30 31 or more

Former Smoker When did you start smoking? _____ When did you quit smoking? _____

Alcohol Use

Did you have a drink containing alcohol within the past year? Yes No

How often did you have a drink containing alcohol in the past year?

Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

1-2 drinks 3-4 drinks 5-6 drinks 7-9 drinks 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?

Never Less than monthly Monthly Weekly Daily or almost daily

Drug Use

Have you used drugs other than those for medical reasons in the past 12 months? Yes No

If yes, what substance? _____

Current Symptoms/Problems

General:

	YES	NO
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Generalized Body Aches	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Exercising	<input type="checkbox"/>	<input type="checkbox"/>

HEENT:

Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Ear Drainage	<input type="checkbox"/>	<input type="checkbox"/>
Ear Itching	<input type="checkbox"/>	<input type="checkbox"/>
Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Drainage	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeding	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Postnasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>

Eyes:

Itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>
Drainage	<input type="checkbox"/>	<input type="checkbox"/>
Vision Changes	<input type="checkbox"/>	<input type="checkbox"/>
Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>
Red Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Puffy Eyes	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory:

Cough	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO		YES	NO
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	Sputum Production	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Chest Tightness	<input type="checkbox"/>	<input type="checkbox"/>
Heart:			Nervous:		
Chest Pain at Rest	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain on Exertion	<input type="checkbox"/>	<input type="checkbox"/>	Weakness of arms	<input type="checkbox"/>	<input type="checkbox"/>
Heart Beating Fast	<input type="checkbox"/>	<input type="checkbox"/>	Weakness of legs	<input type="checkbox"/>	<input type="checkbox"/>
Passing Out	<input type="checkbox"/>	<input type="checkbox"/>	Restless feeling in legs	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal:			Endocrine:		
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Increased Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Increased Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Intolerance to Heat	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Intolerance to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric:		
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Feeling Depressed	<input type="checkbox"/>	<input type="checkbox"/>
Sleep:			Feeling Anxious	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Vascular:		
Difficulty Falling Asleep	<input type="checkbox"/>	<input type="checkbox"/>	Bruises Easily	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Daytime Sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding on minor cuts	<input type="checkbox"/>	<input type="checkbox"/>
Interrupted Sleep	<input type="checkbox"/>	<input type="checkbox"/>	Skin:		
Genitourinary:			Dry	<input type="checkbox"/>	<input type="checkbox"/>
Increased Urine Frequency	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>
Pain while urinating	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal:			Swelling (Angioedema)	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pains	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>			
Muscle Pains	<input type="checkbox"/>	<input type="checkbox"/>			

How long have you had your symptoms? _____

How often do your symptoms occur? Daily Weekly Monthly Occasionally
 When do your symptoms occur? Winter Spring Summer Fall All Seasons

Symptoms are **better** when: (Check all that apply)

- Resting
- Weather Changes
- Exercising
- Indoors
- Taking Medications
- Around Smoke

Symptoms are **worse** when: (Check all that apply)

- Exercising
- Stressed
- Eating
- Weather Changes
- Drinking
- Traveling
- Around Fumes/Odors
- Outdoors
- Indoors
- Around Animals

How severely do these symptoms interfere with your daily life?

1 2 3 4 5 6 7 8 9 10 (Most Severe)

Have you been tested for allergies before? Yes No If yes, what year? _____
 Did you start allergy shots? Yes No If yes, were they beneficial? Yes No

Household Information

Check all that apply to describe the patient's bedroom:

- Carpet Floors
- Linoleum Floors
- Wood Floors
- Tile Floors
- Mattress
- Box Spring
- Waterbed
- Dust Covers
- Blankets
- Quilts
- Rugs
- Curtains
- Blinds
- Ceiling Fan
- Bookcase
- Plants
- Stuffed Toys
- Feather Pillows, Mattress or comforters

Do you have any pets? Dog(s) Cat(s) Bird(s) Rabbit(s) Horse(s) Other: _____

Hobbies: _____

Patient Instruction/Consent Form for Allergy Skin Testing

Skin tests are methods of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a wheal, swelling, or flare in the surrounding area of redness). The results are read at 15 to 20 minutes after the application of the allergen.

The skin test methods are:

Prick Method: The skin is pricked sharp device that introduces the allergen into the skin.

Intradermal Method: This method consists of injecting small amounts of an allergen into the superficial layers of the skin.

The entire testing process will take about 60 minutes, depending on the reaction. We test a variety of important allergens that are found in our region including trees, grasses, weeds, molds, dust mites, and animal dander. After administering the allergens, we wait approximately 20 minutes to review the results. A positive reaction occurs when the skin becomes red, raised, and itchy. The skin reaction will gradually dissipate within 30-60 minutes. Some people will experience local swelling beginning 4-8 hours after testing. This is not serious and typically no treatment is required. It should disappear in the next few days. Less than 1% of patients may develop systemic reactions to skin testing, which may consist of any or all the following symptoms: itchy eyes, nose, or throat, nasal congestion, runny nose, tightness in the throat or chest, wheezing, lightheadedness, nausea or vomiting, hives, or anaphylactic shock. This is very rare, but in the event of such reactions, the staff is fully prepared and emergency equipment is readily available.

Some medications interfere with skin testing results:

Antihistamines must be discontinued 5-7 days before skin testing. These are found in many over-the-counter cold medicines, sinus tablets, hay fever medications or pills taken for itchy eyes or skin. Popular drug names include diphenhydramine (Benadryl), Chlorpheniramine (Chlor-Trimeton), fexofenadine (Allegra), azelastine (Astellin, Optivar), cetirizine (Zyrtec), promethazine (Phenergan), olopatadine (Patanol, Patanase), ebastine (Evastin, Aleva), and epinastine (Elastat). Claritin, Claritin D, Loratidine, Desloratidine, and Clarinex.

Beta-Blockers including carvedilol (Coreg), labetalol (Normodyne), nadolol, pindolol, propranolol (Inderal), sotalol, timolol, atenolol (Tenormin), esmolol, and metoprolol (Lopressor, Toprol).

Tricyclic Antidepressants including amitriptyline (Elavil, Tryptizol, Laroxyl), doxepin (Adapin, Sinequan), imipramine (Tofranil, Janimine, Praminil), nortriptyline (Pamelor, Aventyl), and propizepine (Depressin, Vagran).

Most drugs do not interfere with skin testing but be certain that the office has an updated medication list at each visit. The following medications are commonly asked about and are OK to take while undergoing skin testing:

Nasal Steroid Sprays including fluticasone (Flonase, Veramyst), triamcinolone (Nasacort), mometasone (Nasonex) beclomethasone (Vancenase, and budesonide (Rhinocort).

Asthma medications including albuterol (Proventil, Ventolin), fluticasone/salmeterol (Advair), beclomethasone (Beclivent, Vancerial), ipratropium (Atrovent), flunisolide (Aerobid), triamcinolone (Azmecort), theophylline, methylprednisolone (Medrol), and prednisone (Sterapred).

Pregnant women should not undergo allergy skin testing.

I have read the patient information sheet on allergy skin testing and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of allergy skin testing and these questions have been answered to my satisfaction.

Printed Name of Patient or Responsible Party

Signature of Patient or Responsible Party

Date