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

ADVANCED allergy asthma sinus CARE

CHILD PATIENT EVALUATION

Name ______________________________ Date ______________

The main problem for bringing your child here is: ______________________________

____

____

____

PHYSICIAN'S NOTES

PLEASE COMPLETE EVERY BOX "YES" OR "NO"

NOSE			
Do your child's 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)?			
Does your child use, or has your child ever 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	
Does your child use, or has your child 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 your child sleepy?	☐ Yes	☐ No	

EYES			
Do your child's 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)?			
Does your child use, or has your child 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			
Has your child ever been diagnosed as having sinusitis (a sinus infection)?	☐ Yes	☐ No	**PHYSICIAN'S NOTES**
Has your child ever had a sinus CT Scan?	☐ Yes	☐ No	
If ***YES***, were the results normal?	☐ Yes	☐ No	
Has your child ever had a sinus x-ray?	☐ Yes	☐ No	
If ***YES***, were the results normal?	☐ Yes	☐ No	
Does your child have:			
Postnasal drip?	☐ Yes	☐ No	
Frequent headaches?	☐ Yes	☐ No	
Snoring?	☐ Yes	☐ No	
Previous Ear, Nose & Throat physician (if applicable) was			
History of sinus or nose surgery?	☐ Yes	☐ No	

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

EARS		
Has your child had frequent ear infections?	☐ Yes ☐ No	PHYSICIAN'S NOTES

SKIN		
Has your child ever had skin allergies?	☐ Yes ☐ No	
If ***YES***: ☐ Hives ☐ Eczema		

GI		
Has your child ever been diagnosed as having gastroesophogeal reflux?	☐ Yes ☐ No	

PAST MEDICAL HISTORY				
Other chronic health conditions:				
			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	

IMMUNIZATION/DEVELOPMENT STATUS		
Is your child's immunization status up-to-date?	☐ Yes ☐ No	
Has your child had appropriate growth and developmental milestones?	☐ Yes ☐ No	

PAST ALLERGY HISTORY		
Are your child allergic to any (if *YES*, please list):		**PHYSICIAN'S NOTES**
Food	☐ Yes ☐ No	
Insect Venom	☐ Yes ☐ No	
Medicine	☐ Yes ☐ No	
Has your child ever had allergy testing?	☐ Yes ☐ No	
If YES, testing was done by Dr.________________	In ________________ (month) (year)	
Has your child 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	
If severe reaction please explain:		

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

CURRENT ENVIRONMENT						
Does your child live in a: ☐ House ☐ Apartment ☐ Condominium ☐ Townhouse ☐ Mobile Home ☐ Other						
Does he/she have:						
Cats	☐ Yes	☐ No	Cigarette smoke	☐ Yes	☐ No	
Dogs	☐ Yes	☐ No	Air conditioning	☐ Yes	☐ No	
Birds	☐ Yes	☐ No	Mold growth	☐ Yes	☐ No	
Other pets If yes, please list	☐ Yes	☐ No	Air cleaner	☐ Yes	☐ No	
			Ceiling fans	☐ Yes	☐ No	
			Curtains/Drapes	☐ Yes	☐ No	
Down comforter	☐ Yes	☐ No	Carpets or rugs	☐ Yes	☐ No	

FAMILY HISTORY					
	Allergies	Asthma	Sinusitis	Frequent Cough	**PHYSICIAN'S NOTES**
Mother					
Father					
Brother(s)					
Sister(s)					
Grandmother(s)					
Grandfather(s)					
Uncle(s)					
Aunts(s)					
Cousin(s)					
Does your child's family history include other 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		**PHYSICIAN'S NOTES**
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.)		