Fowler Allergy
Laurie B. Fowler, MD

New Patient Registration

Patient Name:_____Birthdate:_____Age:_____

Address:_____

Social Security (SS) #:_____Marital Status:_____Sex:_____

Home Phone:_____Cell Phone:_____Email:_____

Employer:_____ Occupation:_____

Emergency Contact:_____Relationship:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Responsible Party or "Bill To" Information

Full name:_____Relationship:_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Birthdate:_____Age:_____SS #:_____

Employer:_____

Primary Insurance

Insurance carrier:_____Policy Number:_____Group Number:_____

Subscriber's Name:_____Subscriber's Birthdate:_____SS #:_____

Secondary Insurance

Insurance carrier:_____Policy Number:_____Group Number:_____

Subscriber's Name:_____Subscriber's Birthdate:_____SS #:_____

Primary Care Physician

Dr:_____Phone:_____

How did you learn about us

Friend Relative Google Insurance Website Physician:

1506 Chapel Hill Road Suite G Columbia, MO 65203 573-234-2600 Fax 573-234-2622
www.fowlerallergy.com

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Patient History

Patient Name:_____ Birthdate:_____

What is the reason for your visit today? _____

_____

Please list any physicians or practitioners currently involved in your care:

_____

List your present medications (over-the-counter, prescription, and herbal supplements):

Medications	Dosage and frequency

Do you have any drug allergies? Vaccine reactions? List and explain reaction:

_____

Do you have any known food allergies or sensitivities? List and describe how you feel when you eat them:

_____

List all past/present medical illnesses:_____

_____

_____

List previous surgeries/hospitalizations, including the dates: _____

_____

Date of prior chest x-ray: _____ _____ _____

Date of prior EKG: _____ _____ _____

Date of prior allergy test: _____ _____ _____

List all serious illnesses in your immediate family (diabetes, heart disease, high blood pressure, asthma, etc.):

Illness	Family Member

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Allergy History Questionnaire

Patient Name:_____ Birthdate:_____

Have you had allergy testing done in the past? Yes No

If so, when and where was the testing done?_____

Do you have animals/pets? Yes No

What types of animals?_____

Are they inside your home? Yes No

In your bedroom? Yes No

Do you have any feather pillows? Yes No

Do you have dust mite encasements on pillows or mattresses? Yes No

Do you have a HEPA filter? Yes No

Do you have a Humidifier? Yes No

Do you have a dehumidifier? Yes No

Do you open the windows of your home? Yes No

Do you have an attic fan? Yes No

What type of heat do you have? (circle one)

Gas Electric Ground source Wood stove Other

Do you have a fireplace? (circle one)

Gas Wood burning

How often is it used?_____

Do you live in a house, manufactured home, or apartment? Own or rent? (circle)

How old is the place where you live?_____

How long have you lived at this location?_____

Do you have a basement? Crawl space? (circle)

Is it dry or damp?

Finished or unfinished?

Any history of water damage? Yes No

Do you smoke or have a history of smoking? Yes No

How much do you smoke per day or when did you quit?_____

Do you live with any smokers? Yes No

If yes, do they smoke inside? Yes No

Do you chew tobacco? Yes No

Do you drink? Yes No

If yes, circle preferred drinks: wine beer whisky other spirits

Do you have a history of alcohol or substance abuse? Yes No

Are you on blood thinner? Yes No

Marital status (circle one): married single divorced widowed child

Who do you live with?_____

Where do you work?_____

What is your occupation?_____

Do you feel worse at work? Yes No

Are you exposed to any perfumes, chemicals, or irritants with your occupation? Yes No

If yes, explain where and how much exposure you have:_____

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Allergy History Questionnaire

Patient Name:_____Birthdate:_____

Do you now, or have you had, any problems related to the following? Circle Now (N), Past (P), or leave blank.

Ear:			**Mouth:**			**Skin:**		
Decreased Hearing	N	P	Sores on tongue	N	P	Skin rash	N	P
Pain	N	P	Bad breath	N	P	Boils	N	P
Fullness	N	P	Lumps/growth	N	P	Persistent itch	N	P
Infection	N	P	Bleeding	N	P			
Ringing	N	P	Pain	N	P	**Musculoskeletal:**		
Dizziness	N	P	Gums/swelling	N	P	Joint pain	N	P
Hearing Aid/s	N	P				Neck pain	N	P
			Eyes:			Back pain	N	P
Nose:			Redness	N	P	Hypermobility	N	P
Blockage/breathing	N	P	Watery	N	P			
Congestion	N	P	Itching	N	P	**Respiratory:**		
Drainage	N	P	Change in vision	N	P	Wheezy	N	P
Infection	N	P				Frequent cough	N	P
Trauma	N	P	**Neurological:**			Shortness of breath	N	P
Sneezing	N	P	Headache	N	P			
Bleeding	N	P	Migraine	N	P	**Hematological/Lymphatic:**		
Loss of smell	N	P	Numbness/tingling	N	P	Swollen glands	N	P
			Tremors	N	P	Blood clotting problems	N	P
Throat:			Dizzy spells	N	P			
Lumps/growth	N	P				**Psychological/Emotional:**		
Pain	N	P	**Endocrine:**			Medication	N	P
Swelling	N	P	Too hot/cold	N	P	Depression	N	P
Loss of voice	N	P	Tire/sluggish	N	P	Anxiety	N	P
Abscess	N	P	Thyroid	N	P	ADHD	N	P
Tonsillitis	N	P				Behavioral problems	N	P
Hoarseness	N	P	**Gastrointestinal:**					
Voice change	N	P	Indigestion/heartburn	N	P	**Allergic/Immunological:**		
			Nighttime cough	N	P	Hives	N	P
Sinus:			Abdominal pain	N	P	Hay fever	N	P
Infection	N	P	Nausea/vomiting	N	P	Drug allergies	N	P
Congestion	N	P	Other:			Food allergies	N	P
Polyps	N	P				Picky eater	N	P
Eye/facial swelling	N	P	**Cardiovascular:**			MTHFR	N	P
Change in vision	N	P	Pericarditis	N	P			
Pain	N	P	Low blood pressure	N	P	**Hormones:**		
Pressure	N	P	Chest pain	N	P	Low testosterone	N	P
Drainage	N	P	High blood pressure	N	P	Menopause	N	P
Headaches	N	P	Arrhythmia issues	N	P	Abnormal levels	N	P

Clinic use only

Laurie Fowler M.D._____ Date_____

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Notice of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its *Notice of Privacy Practices* occasionally and I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Assignment of Benefits and Authorization to Release Medical Information

I request that payment of authorized benefits of my Insurance Carrier be made on my behalf to the provider listed on this form for any services furnished to me by the provider. I authorize any holder of medical information about me to release necessary information to determine these benefits or the benefits for other related services to the listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s).

Signature: _____

Date: _____

Clinic use only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices, Assignment of Benefits, and Authorization to Release Medical Information, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

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Financial Responsibility Form

I agree to pay for any and all medical services I receive from the doctors and ancillary providers (antigen fees, laboratory fees, etc.) of this practice should my insurance company refuse to pay for my care, or if my insurance coverage lapses. It is my (patient/patient's caregiver) responsibility to know my insurance coverage. Should I be contracted with two insurance policies I understand and agree that unless I can provide verification of an established coordination of benefits neither policy will be eligible for billing.

There may be services not covered by my insurance, and I agree to pay in full any and all charges that may be denied as "not medically necessary" by my insurance carrier. This includes all allergy testing including prick and intradermal testing, antigen treatment vials, antigen administration, and nebulizer treatments. I acknowledge and agree that some insurance companies only cover a limited amount of antigen doses per rolling 12 month time frame, and I agree to pay the remainder in full should that situation arise.

I further agree and understand that this office can only code and file a claim for my visit(s) with the diagnosis that was encountered and documented in my medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

Should my insurance carrier refuse payment (e.g., non-covered services, my failure to secure a referral from my primary care physician, services deemed "not medically necessary" by my insurance provider, missing coordination of benefits, the doctor is not a panel member of my medical group / Independent Practice Association, etc.), I will pay for all services rendered upon receiving a written and/or verbal notice of the denial of my claim.

In the event I do not pay for these or any other services provided to me when due, having been provided at least 2 billing statements, I agree to pay all costs associated with collection, including reasonable attorney fees (whether or not a lawsuit is commenced) as part of the collection process.

By my signature, I certify to having read the above statements and fully understanding my financial responsibility for all care rendered to me so long as I am a patient of this practice regardless of any changes in my insurance coverage.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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