Please complete and bring these forms with you to your appointment.

Family Allergy Clinic

Dr. Melissa Ferrell, DNP FNP-BC
Dr. J Carvel Jackson, DO

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: ____

Preferred Name:_____ Sex: _____ Date of Birth: _____

Social Security: _____ Email Address: _____

Cell Phone: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Method of Contact: _____Would you like email appointment reminders? _____

Payment Information:

If you do not have insurance or your service is not covered by insurance, payment is required at the time the service is rendered. We will be happy to bill your primary medical insurance for our services. In order to do this, we require complete and accurate insurance information. All patients are responsible for their own balances. If your insurance does not pay after 60 days, we will either bill you or ask you for your intervention with your insurance carrier to get the claim paid. If any proceedings or actions shall be brought against me to recover any outstanding balance, the undersigned agrees to pay all costs and expenses acquired including reasonable attorney's fees. Please complete your insurance information below:

Insurance company name: _____ Plan Name/Type: _____

Insurance ID #: _____ Group ID#: _____

Claim address: _____

Effective Date: _____ Relation to Insured: _____

Policyholder name: _____ Policyholder date of birth: _____

Policyholder sex: _____ Policyholder social security #: _____

Policyholder address: _____City: _____ State: ____ Zip: _____

Phone: _____

Employer Name: _____ Employment Status: _____

Employer Address: _____ City: _____State: ____ Zip: _____

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Responsible Party Information:

Relationship to Patient: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Social Security: _____

Primary Phone: _____ Secondary Phone: _____

Demographics:

Ethnicity: _____ Race: _____ Preferred Language: _____

In case of emergency notify: _____

Relation to Patient: _____Phone: _____

If the patient is a minor: I hereby certify that I am legal guardian of the above minor and authorize the healthcare provider to perform the necessary procedures required for medical evaluation and treatment.

The patient/responsible party acknowledges that the above information is true and correct, accepts responsibility for all services rendered, and that he/she is contractually bound to pay for services rendered.

Signature: _____ Date: _____

Your payment portion/copay are due at the time of each visit. Payment is due immediately upon receipt of a statement from us or upon receipt of explanation of benefits from your insurance carrier. We do not bill any third party insurances. Therefore, you are responsible for payment for those types of services.

No-Show/Cancellation Policy:

If you are unable to keep your scheduled appointment, please notify us by phone at least 24 hours in advance. Patients who fail to do so will be assessed a fee of $35.00.

I have read and understand the above information. I accept financial responsibility for my services as outlined above. I request that payment of authorized insurance benefits be made either to me or on my behalf to the Family Allergy Clinic and/or Allergy Navigators, PLLC. I authorize medical or other information needed for my claims to be released to the insurance carrier(s) or Health Care Financing Administration. I permit a copy of the authorization to be used in place of the original.

Signature: _____ Date: _____

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Consent for Treatment

Allergy Testing

If my provider deems allergy testing is necessary to identify environmental and/or food allergies a percutaneous skin test will be performed. This testing involves introducing allergen extracts under the skin to assess the severity of your reaction. This may cause temporary discomfort, itchiness, redness, and/or swelling. In the rare chance that a severe reaction occurs, precautions will be taken.

I, _____ agree to testing today for the purpose of identifying my allergies. I hereby understand the testing side effects, and waive any claim, action, cause against the Family Allergy Clinic, Dr. Melissa Ferrell, DNP FNP-BC, Dr. J Carvel Jackson, DO and/or staff members due to the possible side effects I may suffer. Provided such reactions are not due to negligence or other inappropriate acts of the clinician or staff members.

Signature: _____ Date: _____
If minor child, signature of parent/legal guardian: _____

For minor child: I understand that my child cannot be treated without my presence unless I've given written consent to an adult over 18 to seek such care or treatment. In my absence the following adults over the age of 18 may seek medical attention for my minor child:

Name _____ Relationship _____
Name _____ Relationship _____

Sublingual Immunotherapy (allergy drops)

Your provider may recommend sublingual allergy drops. These drops are for your allergic reactions to environmental and/or food allergens. It is recommended that the allergy drops be taken for 3-5 years for sustained allergy relief. You will be required to follow up with a clinician every three (3) months for the first year of treatment to assess how the drops are working for you. At the time of your follow up visit, you will be provided with a refill of your allergy drops. You will be required to follow up with a clinician every 6-12 months after the first year of treatment to continue with the allergy drops. Some insurance companies do not cover the sublingual allergy drops. If your insurance does not cover the drops, you are responsible to pay for each prescription out-of-pocket at the time of service.

I, _____ understand that my insurance company may not cover the cost of the allergy drops and that I have read and understand the above information. I accept financial responsibility for my services as outlined above.

Signature: _____ Date: _____

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ALLERGY HISTORY SURVEY

Date:_____

Patient Name:_____ _____D.O.B._____ M / F

Please complete the following allergy surveys according to their severity as outlined:

0= absent, no symptoms present; **1**=mild, symptoms present occasionally; **2**=moderate, symptoms present frequently but tolerable; **3**=severe, symptoms constant and uncontrollable

SEASONAL ALLERGIES: ☐ N/A

1. Nasal Discharge	0	1	2	3	6. Watery Eyes	0	1	2	3
2. Nasal Obstruction	0	1	2	3	7. Itchy Eyes	0	1	2	3
3. Nasal Itching	0	1	2	3	8. Gritty Eyes	0	1	2	3
4. Sneezing	0	1	2	3	9. Wheezing	0	1	2	3
5. Cough	0	1	2	3	10. Breathing Difficulties	0	1	2	3

Are you currently being/have you ever been treated for Asthma □No □Yes

How frequently do you use medication to control your asthma?_____

FOOD ALLERGIES: ☐ N/A

Do you have any history of anaphylaxis requiring an Epinephrine/Adrenaline Injection? □No □Yes

Do you currently carry an Epi-Pen? □No □Yes

Please list any foods you have noticed/had an allergic reaction to below:

Food:	Symptoms:
_____	_____
_____	_____
_____	_____
_____	_____

HIVES: ☐ N/A

When was your first episode?_____

How often do you have outbreaks?_____

Which medications have you used to treat your hives?_____

ECZEMA: ☐ N/A

When did your eczema begin?_____

How frequently do you experience flares? □ Constantly □ Seasonally, which season?_____ □Randomly

Which medications have you used to treat your eczema?_____

OTHER: ☐ N/A

1. Headache	0	1	2	3	4. Frequent Colds	0	1	2	3
2. Sinus Infections	0	1	2	3	5. Frequent Sore Throat	0	1	2	3
3. Ear Infections	0	1	2	3	6. Post Nasal Drip	0	1	2	3

Are there any other symptoms or concerns you would like to address today?

_____

_____

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MEDICATIONS: ☐ N/A

Please complete the following medication survey as outlined:

0= never, 1= occasionally(several times a month), 2=frequently(several times a week), 3= daily

1. Antihistamines	0	1	2	3	3. Oral Steroids(Prednisone)	0	1	2	3
2. Nasal Steroids	0	1	2	3	4. Eye Drops	0	1	2	3

Please list all current medications and dosages:

_____ _____

_____ _____

_____ _____

_____ _____

Medicationallergies/reactions:_____

_____

ALLERGY HISTORY

How many months of the year do you have allergies?_____ What year did your allergies begin?_____

In what season(s) are your allergies worst? □Spring □Summer □Fall □Winter

Have you previously had allergy testing done? □No □Skin Prick/Scratch Testing □Blood Draw □Other_____

Have you previously received: □Allergy Shots □S.L.I.T.(Allergy Drops) If yes, when?_____

Do you currently or have you ever smoked or used tobacco products? □No □Yes Year Quit_____

Do you currently have animals in or around the home? □No □Yes

If yes, what kind?_____

Do you have family members with allergies? □No □Yes

If yes, who?_____

PAST MEDICAL HISTORY

Please mark those questions to which your answer is yes and explain when you were diagnosed and/or were treated, leave all others blank:

□Heart disease_____ □High blood pressure _____

□Cancer _____ □Diabetes_____

□Epilepsy or seizures_____ □Stroke_____

□Mental Illness_____ □Thyroid problems_____

□Bronchitis_____ □Abnormal chest X-ray_____

□Ear Surgery/Tubes_____ □Sinus Surgery_____

□Adenoidectomy_____ □Pneumonia_____

□High cholesterol_____ □Other lung diseases_____

□Dizziness or fainting spells_____ □Tonsillectomy_____

□Depression_____

How did you hear about the Family Allergy Clinic?

□ Google Search □Family or Friend, what is their name:_____

□Dr. Referral □Advertisement in a Paper or Newsletter, which one:_____