Mt. Lebanon Allergy Associates, Inc.
Mina Patel M.D.
Phone: 412-405-8475 Fax: 412-278-1399

JMA Building, 1200 Brooks Lane, Suite 250
Jefferson Hills, PA 15025

St. Clair Hosp. Prof bldg., 1050 Bower Hill Road, Suite 303
Pittsburgh, PA 15243

NEW PATIENT PAPERWORK

Patient Name: ______________________________________Today's Date:________________
First Middle Last

Home Address: ____

City: __________________State: ___________ Zip: _______Birthdate: __________________

Telephone: _______________________ Circle one (home/cell) Email: ____________________

Occupation: ____________________________Social Security Number: _________________

Employer: ______________________________Employer phone #: ______________________

Employer Address: ____

Primary care physician name: ________________________ phone: ____________________

Primary care physician address: ____

Status: Please circle one- Single Married Divorced Widow Legally separated

Name of Spouse: ___________________________________ Birthdate: __________________

Spouse Occupation: ________________________________ Phone: ____________________

Employer: ______________________________ Employer Phone: _______________________

Employer Address: ____

PLEASE PROVIDE US WITH THE NAME AND PHONE NUMBER OF THE NEAREST RELATIVE NOT LIVING WITH YOU:

In the event of Emergency, Contact: ________________________Relationship:___________

Home Phone: _______________ Work Phone: ________________Cell: __________________

Referred By: Dr. ______________________________ Phone: ___________________________

Are there any members of your family seen in our office as patients? If so, please list names:

____

How did you learn about Mt. Lebanon Allergy Associates? _________________________________

INSURANCE INFORMATION

Patient's Name: ___________________________________ Today's date:_______________
First Middle Last

Primary

Primary Insurance Name: ____

Policy: ________________________________Group Number: ___________________

Primary Card Hold Name: ___________________________Birth Date: ____________

Social Security Number: _________________ Employer Name: _________________

Secondary

Secondary Insurance Name: ____

Policy: ________________________________Group Number: ___________________

Primary Card Hold Name: ___________________________Birth Date: ____________

Social Security Number: _________________ Employer Name: _________________

Race: White______ African American______ Hispanic________ Other__________

Language: English_____`______ Spanish__________ Other_________________

Pharmacy: ______________________**Address:** _____________________________**Phone:** _____________

Please remember you are responsible for all fees of non-covered services, deductibles, co-payments and balances of fees not paid by insurance companies which we do not participate with.

Signature of Patient or Legal Guardian: ___________________________ Date: ___________

I authorize the release of any medical information necessary to process any claims on this patient's behalf.

Signed: _________________________
(Patient or authorized person)

Date: ___________________________

I authorize payment of medical benefits to Mt. Lebanon Allergy and Associates, Minaxi Patel, MD.

Signed: _________________________
(Patient or authorized person)

Date: ___________________________

Current medications/medical history

Medication: Please list all current medications including over the counter medications and herbal supplements. (Use the back of page if necessary)

Medication:	**Dose:**	**Time of day taken:**
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Hospitalizations:

Procedure:	**Date of procedure:**	**Comments:**
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Social History: **Circle one**

Do you currently smoke? (yes) (No) How many per day? __________ How long have you smoked? _________

Have you ever smoke? (yes) (No) How many per day? __________ How long did you smoked? ___________

When did you stop smoking? ______________________________________

Do you drink alcohol? (yes) (No) How much? _________________ How often? ________________________

Do you use any other recreational drugs? (yes) (No) How much? _________________ How often? __________

Family Medical History

Family History:

Please list family member with the following disease:

Disease	***Family member***	***Paternal relative***	***Maternal relative***
Heart Disease			
Stroke			
Diabetes			
High blood pressure			
Asthma			
Hay Fever or Allergy nose problems			
Eczema			
Drug Allergies			
Food Allergies			
Insect Allergies			
Sinusitis			
Bronchitis and/or Emphysema			
Cystic Fibrosis			
Migraine			
Tuberculosis			
Cancer			
Rheumatoid Arthritis			
Systemic lupus Erythematosus			

MT. LEBANON ALLERGY ASSOCIATES

Allergy History

Environmental Exposures:

Symptoms?	***YES***	***NO***
Dogs: (How many____)	___	___
Cats: (How many_____)	___	___
Birds: (How many____)	___	___
Other pets: (How many_____)	___	___
Type_______________	___	___
Feather pillow (s)	___	___

Symptoms?	***YES***	***NO***
Carpet/Rugs	___	___
Air cleaners	___	___
House Plants	___	___
Damp Basement	___	___
Stuffed toys	___	___
Down comforter	___	___

When do your allergy symptoms occur: (check all that apply)

___Spring ___Summer ___Fall ___Winter ___Year round ___At home: (which rooms?)_________________

___At Work ___At school ___Outdoors ___Indoors ___Morning ___Night ___All Day

What makes your allergy symptoms worse: (check all that apply)

______Cold

______Cigarette smoke

______Mowing grass

______Raking leaves

______Perfumes, Colognes, scents and odors

______Dusting/cleaning

______Feathers

______Changes to the temperature and/or relative humidity

______Foods

______Milk and dairy

______Dogs

______Cats

______Hot weather

______Cold weather

______Exercise

______other____________________

<u>Drug Allergies:</u> Please list medication names and describe reactions:

<u>Drug Name:</u>	<u>Reactions:</u>
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

<u>Food Allergies:</u> Please list foods and describe reactions:

<u>Food:</u>	<u>Reactions:</u>
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

<u>Insect Sting Allergies:</u> Please list Insect and describe reactions:

<u>Insect:</u>	<u>Reactions:</u>
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

<u>Latex Allergies:</u> Please describe reaction if sensitive to latex:

____

____

____

____

Review of Systems: Please circle the symptoms that trouble you. If needed, provide additional information in the spaces provided. Systems left unmarked will be considered negative.

Constitutional: Fatigue Malaise Fever Sweats Chills Unexplained weight loss

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Eyes: Red eyes Watery eyes Itchy eyes Puffy Eyes Problem with vision Eye Pain

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Ear/Nose/Mouth/Throat: Earache Itchy ears Decreased hearing Ear plugged Ear Drainage Ringing in the ears Nasal congestion Runny nose Itchy nose Excessive sneezing Frequent nasal bleeding Sinus pain Mouth breathing Snoring Sore throat Itchy throat Tooth/gum pain Post nasal drip

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Cardiovascular: Chest pain Rapid heart rate Irregular heart beat Shortness of breath Problems lying flat Calf pain with walking

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Respiratory: Shortness of breath Cough Wheezing Chest tightness Night time chest symptoms Shortness of breath with exertion

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Gastrointestinal: Heartburn Difficulty swallowing Painful swallowing Nausea Vomiting Diarrhea Constipation Abdominal pain

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Genitourinary: Frequent urination Painful urination Blood or pus in urine Frequent nigh time urination

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Musculoskeletal: Joint pain Joint swelling Muscle pain Muscle weakness

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Integument: Itching Eczema Hives Swelling Easy bruising

Neurologic: Headaches Altered vision Seizures Muscle weakness Dizziness Vertigo Difficulty walking

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Psychiatric: Depressed Anxious Stressed Sad Difficulty getting to sleep/staying asleep Poor appetite

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Endocrine: Goiter Bulging Eyes Intolerance of heat/cold Hand tremor Excessive appetite Weight gain Weight loss Frequent urination Problems with vision

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Hematology/Lymphatic: Easy bruising Frequent bleeding of the nose/gums Excessive menstrual bleeding Anemia Enlarged or painful lymph nodes Weight loss

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MT. LEBANON ALLERGY ASSOCIATES

Asthma and Immunizations

Please answer the following questions <u>ONLY</u> if you have asthma:

When was the diagnosis made? ______________________________

How often do you experience asthma symptoms? ______________________________

Do you have nighttime symptoms? ______________________________

How often do you use your rescue inhaler? ______________________________

Do you experience GERD symptoms (heartburn)? ______________________________

Have you ever had a breathing test (PFT)? ______________ Date of last PFT: ________

Number of missed work/school days in the past year? ______________________

Number of courses of systemic steroids: (prednisone, Medrol)?____________________

When was the last course? ______________________________

Number of Emergency room visits? __________ Date of last emergency room visit: ______

Number of hospital admissions? __________ Date of last hospital admission:________

Number of ICU admissions: ______________ Date of last ICU admission: __________

Do you have a peak flow meter? __________What is your personal best? __________

<u>Immunization History:</u>

	YES	*NO*	*Dates:*
Diphtheria, Pertussis, Tetanus	______	______	____________________
Pollo	______	______	____________________
Measles, Mumps, Rubella	______	______	____________________
Haemophilus Influenza	______	______	____________________
Influenza (flu vaccine)	______	______	____________________
Pneumococcal	______	______	____________________
Varicella (chicken pox)	______	______	____________________
Hepatitis A	______	______	____________________
Hepatitis B	______	______	____________________
Zostavax (shingles)	______	______	____________________
Human Papillomavirus (HPV)	______	______	____________________
Meningococcal	______	______	____________________
Rotavirus	______	______	____________________

MT. LEBANON ALLERGY ASSOCIATES

Health Insurance Portability and Accountability Act HIPAA

I understand that under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information (PHI). I acknowledge I have received a copy of Minaxi G. Patel’s Notice of Privacy Practices regarding my PHI and a more complete description of the uses and disclosures of my/my child’s PHI.

I give consent for Minaxi G. Patel, MD or its staff members to use and disclose PHI about me/my child in order to carry out treatment, payment and health care operations.

I have been given the right to review the Privacy Notice prior to signing this consent. I understand that this practice has the right to change its Notice of Privacy Practices at any time and I may receive a current copy of it.

Minaxi G. Patel, MD or its staff members may call my home or the other specified alternative location and leave a message on a machine or person in reference to any items that assist the practice in carrying out TPO such as: appointment reminders, insurance items, test results or referrals.

Minaxi G. Patel, MD or its staff members may mail to my home or the other specified alternative location any items that assist the practice in carrying out TPO such as: patient statements (marked “Personal and Confidential”), labs or x-rays slips.

Minaxi G. Patel, MD or its staff members may provide outside agencies in the course of treatment, payment and health care operations.

Minaxi G. Patel, MD or its staff members may contact insurance carriers in the course of treatment, payment and health care operations.

I understand that I may revoke this consent in writing at any time, except to the extent that they have taken action relying on this consent.

BY rejecting this consent, Minaxi G. Patel, MD or its staff members has the right to decline treatment of myself/my child.

I authorize you to use or disclose my health information in the manner described above. I also acknowledge that I have received a copy of this practice’s Privacy Policy.

I do give permission to have information released about myself.

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Person(s) with permission to receive information about myself

____

Print Patient Name

____

Signature of Patient Date