Coastal Allergy & Asthma, P.A.
3228 E. 15th Street, Panama City, FL 32405
Phone: (850) 784-2611 Fax: (850)784-2614

NAME:

ACCOUNT # **DOB:**

DATE: **TIME IN:** **REFERRED BY:**

CHIEF COMPLAINTS:

1.

2.

3.

HPI:

Duration:

Severity:

Location:

Time of Year:

Modifying Factors:

Associated Signs and Symptoms:

Any Change In Surrounding/Place:

Change of Medication:

Change of Diet/ Detergents/Shampoos/Toothpaste, Make Up etc.:

Current Medications:	Prescribed Medications on Visit
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.

Preferred Pharmacy______________________________ **Phone#**______________________________

REVIEW OF SYMPTOMS:

Nose:		Respiratory:		Skin:	
Stuffy		Cough		Hives	
Sneezing		Wheeze		Itch	
Itching		Shortness of Breath		Swelling	
Draining		Tightness		Rash	
Bleeding		Phlegm			
Mouth Breathing		Bronchitis		**Musculoskeletal:**	
Snoring		Pneumonias		Muscle pains	
Loss of Smell		Symp. With Exercise		Joint Pains	
Freq. Sinus Infection		Sleep Apnea		Swelling	
Ears:		**Cardiovascular:**		**Foods:**	
Itching		Heart Racing		Allergy	
Popping		Chest Pain		Rash	
Draining		Circulatory Problems			
Ringing		Dizziness		**Endocrine:**	
Hearing Loss		Palpitations		Thyroid	
Fluid In Ears		Fainting		Diabetes	
				Others	
Throat:		**Gastrointestinal:**			
Itching		Abdominal Pain		**Constitutional:**	
Draining		Vomiting		Fevers	
Freq. Clearing		Diarrhea		Weight loss	
Soreness		Constipation		Nightmares	
Hoarseness		Poor Appetite/Weight			
Loss of Taste		Heartburn/Reflux		**Psychiatric:**	
				Depression	
Eyes:		**Nervous System:**		Anxiety	
Itching		Headache		Schizophrenia	
Burning		Tiredness			
Watering		Irritability			
Swelling		Migraines			

PAST MEDICAL AND ALLERGIC HISTORY:

Hospitalizations:
ER Visits: Anaphylaxis Asthma: Others:
Medical: Hypertension: Diabetes: Depression: Thyroid:
Surgery: Tonsillectomy/Adenoidectomy: Sinus Surgery: Others:
Food or Insect Stings Reactions:
Drug Reactions:
Latex:
Immunotherapy in Past:
Immunization Records:

FAMILY HISTORY:

Disease	Parents	Siblings	Children	Grand Parents	Others
Asthma					
Allergy/Hay Fever					
Skin Disease					
Heart Problems					
Depression					
Diabetes					
Hereditary Diseases					
Immunodeficiency					
Cancers					

SOCIAL:

Marital Status:	Smoking: Self
Children:	Others
Occupation:	In House Outside
Hobbies:	No. of Years:
Exercise:	No. of Packs:
Drugs/Alcohol:	Quit When:

ENVIRONMENTAL:

Dwelling Type	Apartment	House	Condo	Mobile Home
Air Conditioning	Central	Separate		
Flooring	Wood	Carpet	Tile	Others
Bedroom Flooring	Wood	Carpet	Tile	Others
Bedding	Feather	Cotton	Other	
Mold	House	Work Place		
Pets	Cats	Dogs	Birds	Others
Indoors/Outdoors				

VACCINATION HISTORY:

YEAR	FLU	PNEUMONIA	TETANUS	OTHERS	SIDE EFFECTS

TESTS ORDERED OR REVIEWS:

Date	Name of Test	Ordered	Reviewed
	CBC		
	Chemistry Panel		
	Immunoglobulins		
	Skin Test or RAST Test		
	PFT and DLCO		
	Sinus X-Rays/CT Scan		
	Chest X-Ray		
	Allergy Panel		
	Hypersensitivity Panel		
	Complements		

EXAMINATION:

Vitals: BP: Pulse: Temp: RR: HT: WT:

GENERAL: Acute Distress +/- Good Mood +/- Co-operative +/- Wheelchair +/-

EYES: Redness +/- R/L Watering +/- R/L Shiners +/- Others

EAR (R): Clear Dull Cerumen Drainage Red Tubes Deafness Scaly Mastoid Pain

EAR (L): Clear Dull Cerumen Drainage Red Tubes Deafness Scaly Mastoid Pain

SINUSES: Tenderness +/- Maxillary R/L Frontal R/L Ethmoids R/L TMJ Pain +/-

NOSE: Hypertrophy +/- R/L Mild Moderate Severe DNS +/- R/L

NECK: Supple +/- Range of Motion Normal/ Abnormal Tenderness +/-

THROAT: Erythema +/- PND +/- Cobble-Stoning +/- Ulcers +/- Discoloration +/-

MOUTH: Ulcers +/- Dentition Good/ Fair Tongue Moist/ Dry Dentures +/-

LYMPH NODES: Cervical +/- Axillary +/- Thyromegaly +/-

LUNGS: Good Air Entry +/- Wheeze +/- Rhonchi +/- Rales +/-

CARDIOVASCULAR: S1 & S2 Normal/ Abnormal Regular Rate Regular Rhythm +/-
Peripheral Pulse +/-

ABDOMEN: Soft +/- Bowel Sounds +/- Tenderness +/- Organomegaly +/-

EXTREMITIES: Edema +/- Discoloration +/- Nails/ Skin Clubbing +/-

SKIN: Rash Hives Papules Macules Plaques Lichenification Hair

NEUROLOGICAL: Head Atraumatic/ Normal Mental Status Orientation x3
Mood/ Affect Good/ Disturbed

DIAGNOSIS OR IMPRESSION:	LABS ORDERED:	SAMPLES GIVEN:

PLAN:

1. Nasal Inhaler ____ Squirt Each Nostril____Times Daily
2. ___________Inhaler____Puff______Daily
3. Montelukast ____ MGS Daily In Am
4. Antihistamine ______ Daily At Night
5. Rescue Inhaler
6. Environmental Changes
7. Asthma Education
8. Consider IT At _________ Months
9. RTC In _______________
10. Time Spent with Patient ___ ________________

SIGNATURE: ____ **DATE:** ______________________________

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Patient Demographics

Today's Date: ______ /______/ ______ Referred By: ______________________________

Patient Information:

Patient's Name: ______________________________ DOB: ______ /______/ ______ Age: __________

Address: ______________________________ City/ Sate/ Zip: ______________________

Social Security Number: ______ - _____ - __________ Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone: (_____) _____-______ Cell (_____) _____-______ Work (_____) _____-______

Email: ______________________________

Preferred method of contact: ☐ Home Phone ☐ Cell. Phone ☐ E-mail ☐ Work

Is it okay to send a text message and/or voice message on your Cell. Phone? ☐ **Yes** ☐ **No**

Do you want to be enrolled in Patient Fusion? (you will be given a code to access your personal records) ☐ Yes ☐ No

We will need an e-mail address for this ______________________________

(Children 12-17 will not be able to have access)

Guarantor Information:

Name: ______________________________ DOB ______/ ______/______ Age: ________

Address: ______________________________ City/ State/ Zip: ______________________

Social Security Number: _____-_____- _______Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced

Home Phone: (_____) _____- ______ Work: (_____) _____ -______ Relationship to Patient: ______________________

Insurance Information

Primary Insurance Company: ______________________________

Policy Number: ______________________Group: ______________________ Phone Number: (_____) _____-______

Address: ______________________________City/ State/ Zip: ______________________

Insureds Name: ______________________ Patient's Relationship to Insured: ______________________

Insureds Social Security Number: ________- __________ - ______________

Secondary Insurance Company: ______________________________

Policy Number: ______________________Group: ______________________ Phone Number: (_____) _____-______

Address: ______________________________City/ State/ Zip: ______________________

Insureds Name: ______________________ Patient's Relationship to Insured: ______________________

Insureds Social Security Number: ________- __________ - ______________

Emergency Contact:

Name: ______________________________ Phone: Home (_____) _____ -________

Relationship to Patient ______________________________Phone: Cell: (_____) _____-________

Consent to Testing

I ______________________________ , consent to be examined and tested for allergies by Dr. Amin of Coastal Allergy and Asthma, P.A. Furthermore I consent and understand that I may be required to undergo allergy skin testing, Patch testing, Oral Challenge, Desensitization, or skin biopsy.

Printed Name: ______________________________ Relationship to Patient: ______________________

Signed: ______________________________ Date: ______________________

Coastal Allergy & Asthma, P.A.

Dr. Binita Amin

3228 East 15th Street, Panama City, FL 32405

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FINANCIAL POLICY

We are dedicated to providing the best possible care for you and we want you to completely understand our financial policies.

1. Payment is due at the time of service(s) unless arrangements have been made in advance.
2. Keep in mind that your insurance policy is basically a contract between **you** and **your insurance company**.
3. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
4. If the balance is not paid in a reasonable amount of time, usually after 3 statements, the balance will be sent to collection, unless prior arrangements have been made.
5. If your check comes back due to Non-sufficient Funds (NSF), there will be a $20.00 charge for each time the bank processes the check.

I have read and understand the practices of this financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by Coastal Allergy and Asthma from time to time.

____ ____________________

Signature of patient (or responsible party, if minor) Date

PERMISSION TO BILL INSURANCE COMPANY

I request that payment of ALL authorized INSURANCE and/or Medicare benefits be either made to me or on my behalf for any services provided by Coastal Allergy & Asthma, P.A.

I authorized any holder of medical or other information about me to release to Coastal Allergy & Asthma, P.A and its agents any information needed to determine these benefits for related services.

I hereby authorized payment directly to Coastal Allergy & Asthma, P.A. of benefits otherwise payable to me. I understand and agree that any unpaid balance not covered by this policy will be payable by me.

Signed:______________________________________ Date:____________________

(Signature of patient (or responsible party, if minor)

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Notice of Privacy Practices

IMPORTANT: THIS NOTICE DESCRIBES YOUR RIGHTS AS A PATIENT. PLEASE REVIEW THIS NOTICE CAREFULLY AND ACKNOWLEDGE RECEIPT BY SIGNING AT THE END OF THE NOTICE.

This organization has a Notice of Privacy Practices in effect. This organization and its employees will share individual patient health information as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. This office is required by law to maintain the privacy of our patient's individual health information and to provide patients with notice of privacy practices with respect to your individual health information. We reserve the right to change the terms of this Notice of Privacy Practices as necessary. A copy of any revised notices will be available in this office. A copy may be mailed to the address maintained on your file.

Treatment, Payment and Health Care Operations. Except as otherwise provided, or with your signed consent form, this office will use and disclose our individual health information as necessary for purposes of your treatment, payment and as necessary and permitted by law, for our health care operations which include clinical improvement, professional peer review, business management, accreditation and licensing, etc.

Family and Friends. With your approval and using our best judgement, individual health information may be disclosed to designated family, friends and others who are involved in your care or in payment of your care. If you are unavailable, incapacitated, or facing and emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited individual health information with such individuals without your approval.

Business Associates. At times, it may be necessary for us to provide your health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associated are required to properly safeguard the privacy of your information.

Appointments and Services. This office may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your individual health information from us by alternative means or alternative locations. You may request such confidential communication in writing and may request that we not send you any further marketing materials and we will use our best efforts to honor such requests. You may make the request by sending your name and address to the Privacy Office at the above address, with your request to be removed from our marketing mailing list.

Other uses and disclosures of your individual health information, permitted or required by law, may be made without your consent or authorization.

- The release of your individual health information for any purpose required by law.
- The release of your individual health information for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.

Printed Name:________________________ **Signature:** _______________________________ **Date:** ___________

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MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your health care provider. In order to give you and all patients the best possible care, we request that you review our policy regarding missed appointments without a phone call or cancellation notice of at least 24-hours.

Please remember that we have reserved an appointment time especially for you. Therefore we request at least a 24 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled appointment time to other patients.

If you are unable to keep your scheduled appointment time, please call our office at least 24-hours in advance in order to avoid a missed appointment fee.

This charge is not covered by insurance.

Your phone call is critical in helping us provide continuous care to all of our valued patients. If you fail to give us notice of your missed appointment, you will be charged a $ 25.00 missed appointment fee.

I have read and understand the policy stated above:

Signature:____ Date:________________________

(Responsible Party)

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PARENTAL CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

To avoid possible delay in providing medical treatment in the event your child becomes ill or injured in your absence.
Coastal Allergy & Asthma offers this form for medical consent and history. It offers assurance that your minor child will receive prompt, personalized attention if you or a guardian is not immediately available.

Please fill out the following form and provide complete copies to each person who is responsible for caring for your child. If care or treatment is needed, they can present this form to the physician or healthcare provider.

Please Note:

- You must complete a separate form for each child and caregiver
- Please update the information at least every six months
- If all blanks are not filled out completely, the form may not be considered valid

Parental Consent for Medical Treatment of a Minor Child

Child's Name:________________________ Date of Birth:____________

Home Address:____
(Street) (City, State, Zip)

Parent's/Guardian's Name:______________ Day ph.________ Eve ph.________

Parent's/Guardian's Name:______________ Day ph.________ Eve ph.________

Home Address:____
(Street) (City, State, Zip)

Alternate phone number(s) (if not at work or home)________________________

I (we) the parent(s) or guardian(s) named above, authorize the following adult caregiver to consent to any necessary examination, anesthetic, blood transfusion, medical diagnosis, etc. and/or hospital care to be rendered to the above-named minor child under the general or special supervision and on the advice of any licensed physician. I (we) agree to pay for all services provided to my child in my absence.

Caregiver________________________ Phone ________________
(OTHER THAN PARENT)

Signatures

Parent or Guardian________________________ Date:____________

Witness________________________ Date:____________

Physician

Child's Physician:________________________ Phone #:____________

Parent's Physician: ________________________ Phone #:____________

BAY DISTRICT SCHOOLS
COMPREHENSIVE HEALTH EDUCATION
PERMISSION TO ADMINISTER MEDICATION

Under the provisions of Section 1006.062, Florida Statutes, any student who is required to take medication during the time they are attending school, including any occasion when the student is away from school property on official school business, may be assisted by the school nurse or other designated school personnel if the school district receives, 1) a written statement from such physician detailing the necessity for the medication to be provided during the school day, including any occasion when the student is away from school property on official school business and the method, amount and time schedules by which such medication is to be taken, and 2) this permission form executed by the parent or guardian of the student granting permission for the school district to assist the student in the matters set forth in the physician's statement I understand that certain educational records of my child will be shared with the district's health care partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such treatment records.

Student's Name____ Date____________________
Address____
Medication__________________________________ Generic Name (if used)______________________________
Route of Administration____________________________________ Dosage Amount_______________________
Time(s) to be administered_____________________ Date to be discontinued (if applicable)__________________
Condition for which drug is to be given____
Note any possible side effects____
It is necessary that the mediation be provided during the school day because_____________________________
____.

If the Student is diabetic and needs to personally carry the supplies, identify the supplies and equipment and describe the level of activities the Student is capable of performing without assistance.
____
____
____

Student May Carry:
- ☐ Inhaler________Physician's Initials
- ☐ Epi-Pen _______Physician's Initials
- ☐ Pancreatic Enzyme Supplement _________Physician's Initial

Physician's Signature____ Date of Request __________________
Physician's Address____
Physician's Telephone____

It is understood there shall be no liability for civil damages as a result of the administration of the medication when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances. **ALL MEDICATION MUST BE BROUGHT TO THE SCHOOL BY A RESPONSIBLE ADULT IN THE ORIGINAL CONTAINER.**

Parent/Guardian Signature____ Date____________________
Parent Address____
Home Phone____________________ Business Phone_________________________ Cell Phone________________

Medication orders must be renewed by the attending physician and this release signed by the parent or guardian at the beginning of each school year. **Note: Students will be allowed to carry and self administer epi-pens and Asthmatic students shall be allowed to carry a metered dose inhaler on their person while in school, if ordered by a physician.**