STONE OAK ALLERGY
ALLERGY | ASTHMA | IMMUNOLOGY
Office: 210-494-0690 | Fax: 210-494-0920
www.stoneoakallergy.com

Welcome to our practice!
We look forward to seeing you!

You are receiving this medical form packet because you have a New Patient Appointment scheduled at Stone Oak Allergy. Please bring all completed paperwork to your appointment.

A few things to remember before your appointment:

1. **Please be sure to bring a valid form of photo ID and all current insurance cards to your appointment. If you do not present current insurance cards on the day of your visit, we will be unable to file to your insurance.**
2. **Please call at least 24 hours before your appointment to cancel or reschedule; otherwise, you will be billed for a $25 No-Show fee.**
3. **Please be sure to wear a mask/face covering.**
4. **If you will be tested for Allergies, remember to discontinue your antihistamines 5 days prior to your appointment. *These medications interfere with testing and accurate results.***

Please feel free to reach out with any questions regarding your appointment or visit our website at www.stoneoakallergy.com

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How did you hear about us?					
Website	Referral	TV/News Ad	Social Media	Radio	Other
Patient Referral: (Name)			Physician Referral: (Name)		

Patient Information		
First Name:	Last Name:	
Address:		
City:	State:	Zip:
Best Phone Number:	Best Email Address:	
Title (Mr./Mrs./Ms.):	Sex/Gender:	Race & Ethnicity:
Marital Status:	Date of Birth:	Social Security Number:

Emergency Contact Information		
Contact First and Last Name:	Contact Phone Number:	Relationship:

Insurance Information	
Policy Holder Name:	Policy Holder Date of Birth:
Insurance Carrier:	Member ID:
Group Number:	Coverage Dates:
Primary Care Physician:	Employer:
Relationship to Patient:	Responsible Party Name and Date of Birth:

Office visit co-pays or deductibles are payable on the day you are seen. Please remember you are responsible for all fees, regardless of insurance coverage.
My signature below confirms that the information provided above is accurate and complete to the best of my knowledge. I consent to the performance of diagnostic procedures, examinations, and rendering of treatment by the medical provider and designated medical staff as it is deemed necessary in the medical provider's best judgement.

Patient Acknowledgement	
Signature of Patient or Responsible Party:	**Date:**

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Financial Responsibility Policy

1. I understand that I, _____, am responsible for knowing whether or not I am—or my dependent is—covered under my insurance policy and that I will bring my current policy information to the clinic at the time of my visit. **INITIALS:**_____
2. I understand that Stone Oak Allergy cannot guarantee that the information received from my insurance company is accurate. I am fully responsible for all charges deemed my responsibility to my account. **INITIALS:**_____
3. I understand that Stone Oak Allergy will bill my insurance company according to all Federal rules and regulations regarding such activities and provides my insurance company with copies of all appropriate and required information and that Stone Oak Allergy is not responsible for lost claims. **INITIALS:**_____
4. I understand that Stone Oak Allergy will make any reasonable effort to assist me in resolving any disputed claims or payment for such claims, but that the contractual relationship for payment of such claims lies solely between myself and my insurance carrier and that I am ultimately responsible for all services provided. **INITIALS:**_____
5. I understand that if my plan is out-of-network or services are determined "non-covered" due to plan provisions and/or preexisting conditions or riders on my policy, I am fully responsible for services incurred. **INITIALS:**_____
6. I understand that if I elect to pay privately at my first visit, due to lack of insurance, lack of coverage, failure to provide my insurance card at the time of service or failure to verify coverage, Stone Oak Allergy will not retroactively submit claim or change account responsibility. **INITIALS:**_____
7. I understand that it is my responsibility to provide accurate and updated insurance information to Stone Oak Allergy at every visit if applicable. **INITIALS:**_____
8. I understand it is my responsibility to proactively be involved in obtaining required referrals that may be required to obtain care depending on my insurance policy. **INITIALS:**_____
9. I understand that Stone Oak Allergy is partnered with a collection agency and that any outstanding balances of 90+ days that have not received payment or established a pre-defined payment plan, will be submitted to the prospective collection agency. **INITIALS:**_____
10. By signing this form, I am aware that in the event I am without health insurance I will be deemed a self-pay patient and financially responsible for all billed services. **INITIALS:**_____

Assignment of Benefits

1. I understand and agree that I am responsible and must pay all deductibles, co-payments, and amounts disputed by my insurance carrier for healthcare services rendered by Stone Oak Allergy to me or my dependent. **INITIALS:**_____
2. I understand and agree that Stone Oak Allergy may utilize any legal means to collect payment for any healthcare services rendered to me or my dependent. In the event that legal action is taken, in order to enforce the terms and conditions of this agreement, the prevailing party shall be entitled to recovery of all attorney and or collection fees and costs. **INITIALS:**_____

No-Show/ Late Fee / Card-On-File Policy

For all appointments, we require a 24 hours' notice in the event of cancellation or rescheduling. If full notice is not provided, we will bill **a $25 no show fee** for medical appointments. Additionally, if you are more than 15 minutes late to your appointment and there is insufficient time to perform the appointment, the appointment may be cancelled or rescheduled and you will be subject to a **$25 fee**.

INITIALS:_____

Our policy is to have an active credit card on file to charge for services, past due balances, payment plans, and no-show fees. I understand that if I opt-out of having a credit card on file, I agree to pay all balances and deductibles, and understand that any unpaid balances could go to collections.

INITIALS:_____

Please indicate a maximum amount per month you authorize your card to be ran for, if you do not have an active payment plan established and have a patient balance due: $_____. *(Minimum amount of $25 is required)* **INITIALS:**_____

****Please complete form on next page****

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Financial Responsibility Policy

Patient Acknowledgement		
Printed name of patient:	**Date:**	**Patient Date of Birth:**
Signature of receipt and acknowledgement of policies listed above:	**Date:**	

Printed name of responsible party/guardian/parent (if under 18 years old:	**Date:**	**Patient Date of Birth:**
Signature of responsible party/guardian/parent (if under 18 years old):	**Date:**	

Credit Card Type:	**Visa**	**Mastercard**	**Discover**	**American Express**	**Other:**
Card Number:				**Zip Code:**	
Security Code:				**Expiration Date:**	
Name on Card:					

By signing below, you acknowledge that you understand and agree to our financial policy and authorize Stone Oak Allergy to use the information above for all payments. You also acknowledge you have read and agree to the Assignment of Benefits, Cancellation and Late Arrival terms. You also understand that HIPAA privacy laws prevent Stone Oak Allergy staff from using the above information for any other purpose.

Signature of Patient or Responsible Party:	**Date:**

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Notice of Patients' Privacy Rights

The notice of privacy practices is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you or your legal dependent (as a patient of this practice) may be used and disclosed, and how you can access to your individually identifiable health information.

Please Review This Notice Carefully

1. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Patient's Privacy Rights ("Notice") that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

a. How we may use and disclose your PHI;
b. Your privacy rights in your PHI; and
c. Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current notice at any time.

2. If you have questions about this notice, please contact:

a. The Privacy and Security Officer at: **512-732-2774**

3. The following categories describe the different ways in which we may use and disclose your PHI:

Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice — including, but not limited to, our doctors and medical assistants — may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your PHI to other healthcare providers for purposes related to your treatment.

Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such service costs, such as family members. Also, we may use your PHI to bill you directly for service and items. We may disclose your PHI to other healthcare providers and entities to assist in their billing and collection efforts.

Healthcare Operations. Our practice may use and disclose your PHI to operate our business. As examples of the way in which we may use and disclose your information for operations, our practice may use your PHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other healthcare providers and entities to assist in their healthcare operations.

Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatricians' office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

Disclosures Required by Law. Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

4. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your PHI:

Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

a. Maintaining vital records, such as births and deaths;
b. Reporting abuse or neglect;
c. Notifying a person regarding potential exposure to a communicable disease;
d. Notifying a person regarding a potential risk for spreading or contracting a disease or condition;
e. Reporting reactions to drugs or problems with products or devices;
f. Notifying individuals if a product or device they may be using has been recalled;
g. Notifying appropriate governmental agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information; or
h. Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the healthcare system in general.

Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

i. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
j. Concerning a death, we believe has resulted from criminal conduct;
k. Regarding criminal conduct at our offices;
l. In response to a warrant, summons, court order, subpoena, or similar legal process;
m. To identify/locate a suspect, material witness, fugitive, or missing person; and
n. In an emergency, to report a crime (including the location or victim[s] of the crime, or the description, identity, or location of the perpetrator).

Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain written authorization to use your PHI for research purposes except when the Practice's Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following:

o. The use or disclosure involves no more than a minimal risk to your privacy based on the following:
    1) An adequate plan to protect the identifiers from improper use and disclosure;
    2) An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and
    3) Adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as

required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted.

p. The research could not practicably be conducted without the waiver.
q. The research could not practicably be conducted without access to and use of the PHI.

Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations.

Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (1) for the institution to provide healthcare services to you; (2) for the safety and security of the institution; and/or (3) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

5. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

Confidential Communication. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy and Security Officer at: **PO Box 5789, Round Rock, TX 78683** specifying the requested method of contact and/or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **PO Box 5789, Round Rock, TX 78683**. Your request must describe in a clear and concise fashion:

a. The information you wish restricted;
b. Whether you are requesting to limit our practice's use, disclosure, or both; and
c. To whom you want the limits to apply.

Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: **PO Box 5789, Round Rock, TX 78683** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed healthcare professional chosen by us will conduct reviews.

Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: **PO Box 5789, Round Rock, TX 78683**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (1) accurate and correct; (2) not part of the PHI kept by or for the practice; (3) not part of the PHI that you would be permitted to inspect and copy; or (4) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a

list of certain non-routine disclosures our practice has made of your PHI. To obtain an accounting of disclosures, you must submit your request in writing to: **PO Box 5789, Round Rock, TX 78683**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of other costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact**: 512-732-2774**.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: **512-732-2774**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care. If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy and Security Officer at: **512-732-2774**.

Patient Acknowledgement	
Signature of Patient or Responsible Party:	**Date:**

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Consent to Release of Medical Information

I, (print patient full name) _____, have read a copy of Stone Oak Allergy's *Notice of Patients' Privacy Rights*. (This document is available at the front desk or online at www.stoneoakallergy.com).

I hereby authorize my personal medical information to be released to the following individuals listed below:

First Name	Last Name	Relationship to Patient	Check One:	
			☐ Medical	☐ Financial
			☐ Medical	☐ Financial
			☐ Medical	☐ Financial

May we have your consent to leave voicemails referencing your personal medical information for the individuals listed above?

☐ Yes, I consent to having my personal medical information left via voicemail for the individual contacts listed above.
☐ No, I do not consent to having my personal medical information left via voicemail for the individual contacts listed above.

If you would like us to leave a voicemail for the contacts listed above, please provide their phone number in the space below:

First Name	Last Name	Phone Number

I, (print patient full name) _____, have read and understand the above information and agree to the terms stated above.

Patient Acknowledgement	
Signature of Patient or Responsible Party:	**Date:**
Signature of Clinical Staff Member:	**Date:**

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Patient Authorization for Email and SMS Text Communication

Stone Oak Allergy will use email and SMS text messages for appointment reminders and emergency purposes only.

Email communications from Stone Oak Allergy are on an encrypted server. Stone Oak Allergy is not responsible for emails reaching any unintended recipients.

I acknowledge that I will inform Stone Oak Allergy of any changes of email address(es) or phone number(s).

I understand that I may be charged for calls or SMS texts by my wireless carrier.

My signature below acknowledges that I have read Stone Oak Allergy's Authorization for Email and SMS Texas Communication and consent to receiving such communication.

Patient Acknowledgement	
Patient First and Last Name	**Date of Birth:**
Signature of Patient or Responsible Party:	**Date:**

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New Patient Assessment Questionnaire

Patient Name:	Date of Birth:
Referring Provider (if applicable) and other providers seen on a regular basis:	
Reason for visit:	

Nasal Symptoms

Have you had any nasal symptoms? If so, what symptoms did you have?

Are these symptoms:

Year-round?	Yes	No	Unsure	
Seasonal?	Yes	No	Unsure	If yes, which season(s)?
Do symptoms improve with travel (outside of the state of Texas)?	Yes	No	Unsure	
Do symptoms worsen around pets?	Yes	No	Unsure	If yes, which pets?

Which medications have you tried to relieve your symptoms and did they help?

Eye Symptoms

Have you had any eye symptoms? If so, what symptoms did you have?

Are these symptoms:

Year-round?	Yes	No	Unsure	
Seasonal?	Yes	No	Unsure	If yes, which season(s)?

Which medications have you tried, and did they help?

Ear Symptoms

Have you had any ear symptoms? If so, what symptoms did you have?

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Respiratory Symptoms				
Do you have any breathing or chest symptoms? If so, what symptoms?				
Have you ever been diagnosed with Asthma?	Yes	No	Unsure	If yes, when were you diagnosed?
Are these symptoms:				
Year-round?	Yes	No	Unsure	
Seasonal?	Yes	No	Unsure	If yes, which seasons?
Do your symptoms worsen with exercise?	Yes	No	Unsure	
Do your symptoms get worse in the cold?	Yes	No	Unsure	
Do your symptoms get worse with infections?	Yes	No	Unsure	
Have you ever been hospitalized or visited an ER for your breathing symptoms?	Yes	No	Unsure	If yes, when:
How often do you have breathing symptoms?				
Have you tried any medications for your breathing symptoms? If so, which ones and did they help?				

Skin Symptoms
Have you had any rashes? If so, please describe them.

Immunodeficiency/Recurrent Infections				
Have you ever been diagnosed with an immunodeficiency?	Yes	No	Unsure	If yes, when were you diagnosed? Describe your diagnosis:
Do you have a history of recurrent infections? Ex: pneumonia; sinus; skin, fungal or atypical viral infections; abscesses, etc.? If so, please describe.				

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Food, Medication, and Insect Allergies

Do you have any allergies or adverse reactions to foods? If so, what foods and what happened?

Do you have any allergies or adverse reactions to medications? If so, what medications and what happened?

Do you have any allergies or unusual reactions to stinging insects (bee, wasp, fire ant, etc.)? If so, which one and what happened?

Medical, Surgical & Family History

Please select any/all medical conditions you have been diagnosed with below:

Eye Conditions

Cataracts	Glaucoma	Other:

Endocrine

Diabetes, Type I	Diabetes, Type II	Hashimoto's Thyroiditis	Hypothyroidism	Hyperthyroidism	Addison's Disease

Other:

Ear, Nose and Throat

Hearing Loss	Deviated Septum	Other:

Cardiovascular (Heart)

High Blood Pressure	High Cholesterol	History of a Stroke	Coronary Artery Disease	History of Arrhythmia	Peripheral Vascular Disease

Other:

Respiratory (Lungs)

COPD	Asthma	History of Pneumonia	History of TB/positive PPD

Other:

Liver and Kidney

Liver Disease	Abnormal Liver Tests	Hepatitis	Kidney Disease	Other:

Other:

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Have you ever been hospitalized or had any surgeries? If so, please list them below:

Please select any family members who have the following illnesses:						
Allergies	Mother	Father	Sister(s)	Brother(s)	Children	Other
Asthma	Mother	Father	Sister(s)	Brother(s)	Children	Other
Eczema or other rashes	Mother	Father	Sister(s)	Brother(s)	Children	Other
Swelling (Angioedema)	Mother	Father	Sister(s)	Brother(s)	Children	Other
Immune Deficiency	Mother	Father	Sister(s)	Brother(s)	Children	Other
Autoimmune Disease	Mother	Father	Sister(s)	Brother(s)	Children	Other

Environmental History					
What is your job?					
What are your current living arrangements, hold old is the structure, and how long have you lived there?					
House	Condo	Duplex	Apartment	Dorm	Trailer

Is there carpeting in your bedroom?	Yes	No		
Do you have air filters in your home?	Yes	No		
Are there dust mite covers on your mattress and/or pillows?	Yes	No		
Is there anything feathered on your bed (pillow, blanket)?	Yes	No		
Is there any tobacco exposure in your home?	Yes	No		
Are there any dogs in your home?	Yes	No	If yes, how many?	
Are there any cats in your home?	Yes	No	If yes, how many?	
Are there any birds in your home?	Yes	No	If yes, how many?	
Are there any mice, guinea pigs, rats, rabbits or any other furred mammals in your home?			Yes	No
Do you have any mold issues in your home?			Yes	No
Are there any workplace exposures, hobbies or recreational activities that worsen your symptoms?			Yes	No
If yes, please specify below:				

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Smoking & Tobacco Use		
Smoking status:		
Have you ever smoked tobacco or other substances?	Yes	No
Are you still smoking?	Yes	No – When did you quit?
If you are a current smoker, how much are you smoking per day and for how long? Ex: number cigarettes per day, number cigars per day, etc.:		

Previous Diagnostics and Studies			
Have you had any of the following imaging studies?			
Chest X-ray, CT, MRI	Yes	No	When/Results:
Sinus CT	Yes	No	When/Results:
Other:			

Have you ever had skin testing? If so, when and what were the results?
Have you ever used immunotherapy/allergy shots/allergy drops? If so, when and did it help?

Current Medications:
Please list your current medications (prescribed and over-the-counter), vitamins, and supplements. When was each started?

Pharmacy Information		
Preferred Pharmacy Name:	Phone:	Address or Intersection: