Patient Demographics

Personal Information	
Last Name	
First Name	
MI	
Address	
City	
State	
Zip Code	
Home Phone	
Work Phone	
Work Extension	
Cell Phone	
Primary Care Physician	
Date of Birth	
Marital Status	
Social Security No.	
Patient's Employer	
Occupation	
Employ. Status	
Student Status	
Referring Physician/Patient	

Emergency Contact	
Last Name	
First Name	
Relation to Patient	
Address	
City	
State	
Zip Code	
Home Phone	
Work Phone	
Work Extension	

Pharmacy	
Name	
Telephone	

Responsible Party	
Last Name	
First Name	
MI	
DOB	
Social Security No.	
Telephone	
Gender	
Address	
City	
State	
Zip Code	
Primary Insurance	
Subscriber	
Relation to patient	
Insurance Name	
Address	
City	
State	
Zip	
Telephone	
Subscriber No	
Group No	
Specialty Co-pay	
Coverage Start	
Secondary Insurance	
Subscriber	
Relation to patient	
Insurance Name	
Address	
City	
State	
Zip	
Telephone	
Subscriber No	
Group No	
Specialty Co-pay	
Coverage Start	

_____

Patient Signature

Medical History

Reason you are being seen today:

Please describe your condition:

Current Medication:	
Medication	Dose

Allergies:	
Medication	Reaction

Medical History	
Condition	Status

Past Surgeries:	
Date	Procedure

Hospitalization:	
Date	Reason

Family History:	
Relative	Condition
Mother	
Father	
Sister	
Brother	
Daughter	
Son	
Maternal Grandmother	
Paternal Grandmother	
Maternal Aunt	
Cousins	
Other	

Social History:	
Occupation	
Alcohol	
Tobacco	
Illicit drugs	
Pet(s), is yes what kind?	
Carpet in bedroom?	

Mold problems in home
House plants?
A/C filters changed?

_____
Signature

ALLERGY & ASTHMA CARE OF HOUSTON, P.A.

HEALTH INSURANCE PORTABILITY AND ACCESSIBILITY ACT PRIVACY NOTICE (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information, please review it carefully.

Uses and Disclosures of Health Information

With your consent,, we may use health information about you for treatment (such as sending your medical record information to other physicians as part of a referral), to obtain payment for treatment (such as sending billing information to health insurance plan), for administrative purposes, and to evaluate the quality of care that you receive (such as comparing patient data to improve health treatment methods).

We may use or disclose identifiable health information about you without your authorization for several reasons: Subject to certain requirements, we may give out your health information for public health purposes, abuse or neglect reporting, auditing purposes, research studies, funeral arrangements, organ donation, worker's compensation purposes, and emergencies. We provide information when requested by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at anytime. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and on our web site. You can also request a copy of our notice at anytime. For more information about our privacy practices, contact Dr. Perez.

Individual Rights

In most cases, you have the right to look at or get a copy of the heath information that is about you, that we use to make decisions about you. If you request copies, we will charge you 10 cents each page. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice is sent electronically, you may obtain a paper copy of the notice.

You may request, in writing, that we not use or disclose your information for treatment, payment, or administrative purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergent circumstances. We may consider your request but are not legally required to accept it.

_____

Signature

ALLERGY & ASTHMA CARE OF HOUSTON, P.A.

Authorization to release information, assign benefits, and accept financial responsibility

I authorize the Allergy & Asthma Care of Houston, P.A. who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to the Allergy & Asthma Care of Houston, P.A. I understand that I am responsible for any co-pay or deductible amounts. I understand that any services denied due to a pre-existing condition clause under my current health coverage are my financial responsibility. I understand I am fully responsible for payment of my account balance if my health plan does not reimburse (or only partially reimburses) my medical services.

_____

Signature

Allergy & Asthma Care of Houston, P.A.	14090 Southwest Freeway, Suite 101 Sugar Land, TX 77478 Office 281.645.6401 Fax 281.277.8872

REQUEST FOR MEDICAL RECORD

To:

Medical Facility:_____

Address: _____

City, State, Zip:_____

Phone: _____

Fax: _____

I hereby authorize the release of all my medical records and test results including HIV test results, in your possession regarding my medical condition. Please send of fax record to:

Dr. Joseph R. Perez
Allergy & Asthma Care of Houston, P.A
14090 Southwest Freeway, Suite 101
Sugar Land, TX 77478
Fax: 281.277.8872

I release you from liability for following this request.

Patient Name:

Date of Birth:

Signature: _____

Date: