2024

PERSONAL INFORMATION *(Please complete each area)*

** If patient is a minor, please fill out **phone and email** information for parent/guardian **

Patient's Legal Name: ______________________ **Date of Birth:** ____________

Home Address: ______________________ **City:** ____________ **State:** ______ **Zip:** ______

Gender: M F Unspecified **Marital Status:** Single Married Divorced Widowed

Social Security Number: ______________________ **Email Address:** ______________________

Primary Phone: ( ) ______________________ **Secondary Phone:** ( ) ______________________

Occupation: ______________________ **Employer Name:** ______________________

Race: ☐ White ☐ Black/African American ☐ Native American / Alaska Native ☐ Asian

☐ Native Hawaiian ☐ Pacific Islander ☐ More Than One Race ☐ Decline to Report

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Decline to Report

Preferred Language: ______________________ ☐ Decline to Report

Preferred Pharmacy: ______________________

EMERGENCY CONTACT INFORMATION *(The office will contact on behalf of patient in even of emergency)*

Name: ______________________ Phone #: ______________________ Relationship: ____________

PRIMARY CARE PHYSICAN INFORMATION *(Required to correspond with your Primary Care Physician)*

Physician's Name: ______________________ Phone Number: ( ) ____________

Practice Address: ______________________ City: ____________ State: ______ Zip: ______

INSURANCE *(This section must be completed in addition to providing a current insurance card)*

Primary MEDICAL Insurance: ______________________ Policy Holder Name: ____________

Policy Holder's SSN: ______________________ Policy Holder's Date of Birth: ____________

Secondary MEDICAL Insurance: ______________________ Policy Holder Name: ____________

Policy Holder's SSN: ______________________ Policy Holder's Date of Birth: ____________

FINANCIAL RESPONSIBILITY

If the patient is a minor (under the age of 18), please complete the following:

Name of Responsible Party: ______________________ Relationship to patient: ____________

Phone #: ____________ Address: ______________________ City: ____________ State: ______ Zip: ______

If someone other than the patient has legal responsibility (i.e., attorney, trustee, POA or former spouse) a copy of appropriate court order and/or legal documents must be provided to office, in addition to the above section being completed.

Patient Financial Policy

Thank you for allowing us to participate in your allergy care. We are committed to providing you with the best possible medical are. If you have medical insurance, we are committed to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our Financial Policy.

In the day and age of health plans, private insurance, Medicare and Medical insurance, we understand that the medical insurance field can be quite confusing. We have attempted to clarify our responsibility to you, our patient, and your responsibility to your carrier.

Medicare/Medicaid: We are providers with Medicare and Medicaid. We agree to bill and accept contractual adjustments for both programs. You are responsible for all deductibles, co-insurance and copays. There may be services and supplies rendered that are not covered by Medicare and therefore require an Advanced Beneficiary Notice (ABN) be signed by the patient/guarantor. By signing the ABN, you understand that you are financially responsible for payment of those services and/or supplies.

Insurance: Your insurance policy is a contract between you and the insurance company. As medical providers, our relationship is with you and not with your insurance company. While the filing of insurance claim forms is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. You are expected to know and follow all regulations or procedures as agreed to by you and your insurance company regarding referrals, second opinions or pre-certifications. We will assist you in obtaining pre-certification for services as needed. Failure to provide correct information (current insurance carrier, policy number, etc.) may result in denial of your claim, and you will be held responsible for the balance. Any out-of-pocket expenses such as deductible, co-insurance and copays must be paid at the time of service. If you belong to an insurance plan that requires a referral from your Primary Care Physician, we cannot see you without a referral unless you pay for the visit yourself.

No Insurance/Self-Pay Patients: Payment in full is due at the time of service.

Forms: There will be a $15 charge for completing forms outside of your office visit. This includes form requests required for school, sports, employment, disability, etc. Payment will be required prior to the completion of the form. This is not covered by insurance and is the responsibility of the patient.

Methods of Payment: We accept cash, check, Visa, Mastercard, American Express and Discover.

Statements: If there is a balance on your account after filing to your insurance carrier, you will received a statement. Payment is expected withing 30 days from receiving your statement If you have any questions regarding your statement, please contact the Billing Department immediately. Due to the high costs for processing statement, we will not send out multiple statements. Your account will be considered delinquent after 30 days from your first statement.

FINANICAL AGREEMENT

I have read and understand the financial policy of Dr. Jennifer Bullock Allergy and Asthma, LLC regarding payments and insurance. I also understand that by signing below, I agree to pay any and all charges on my account that are not covered or have been deemed Patient Responsibility by my insurance company. These charges may include, but are not limited to cop-payments, deductibles, and co-insurance. I understand that if I fail to provided valid, current insurance information to Dr. Jennifer Bullock Allergy and Asthma, LLC before the filing limit, I am responsible for all charges incurred. I also understand that I am responsible for following my insurance plan's regulations, policies and procedures.

______________________________ ______________

Patient/Guarantor Signature **Date**

____

Patient/Guarantor Printed Name

Dr. Jennifer Bullock Allergy and Asthma

www.bullockallergy.com

Acknowledgement of Receipt of Notice of Privacy Practices

& Permission to Share Health Information

I have reviewed the Notice of Privacy practices this day.

Patient Name: ________________________________ Date of Birth: ______________

Patient/Representative Signature: ________________________ Date: ______________

Relationship to patient (in event of Representative Signature):

____

Notification of Family and Friends

I authorize Dr. Jennifer Bullock Allergy and Asthma to disclose my health information to the following persons:

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

Patient Name: ____________________________________ Date: __________

Patient/Representative Signature: ______________________________________

Relationship to patient (in event of Representative Signature):

____

Patient Name ________________________________ Date of Birth______________ Today's Date_________

Please ***check the box*** for any problems or concerns that the above patient is having/has had in the past:

Nose:
- ☐ Sneezing
- ☐ Itchy nose
- ☐ Nasal Congestion
- ☐ Runny Nose
- ☐ Post-nasal drainage
- ☐ Nose rubbing
- ☐ Sniffling
- ☐ Nosebleeds
- ☐ Unable to smell

Sinuses:
- ☐ Polyps in sinus/nose
- ☐ Sinus infections
- ☐ Sinus pain/pressure
- ☐ Sinus headaches

Ears:
- ☐ Ear Infections
- ☐ Fluid behind eardrum
- ☐ 'Plugged' Ears
- ☐ Vertigo/Dizziness
- ☐ Difficulty Hearing
- ☐ Abnormal hearing test

Eyes:
- ☐ Itchy Eyes
- ☐ Red Eyes
- ☐ Watery Eyes
- ☐ Dark circles under eyes

Mouth/Throat:
- ☐ Itchy throat
- ☐ Itchy mouth
- ☐ Throat clearing
- ☐ Sore throat
- ☐ Mucus in throat
- ☐ Hoarse voice
- ☐ Mouth breathing
- ☐ Snoring
- ☐ Sleep apnea

Chest:
- ☐ Cough
- ☐ Wheezing
- ☐ Chest tightness
- ☐ Chest congestion
- ☐ Difficulty breathing
- ☐ Recurrent bronchitis

Skin:
- ☐ Eczema
- ☐ Other type of rash
- ☐ Hives/Welts
- ☐ Itchy Skin
- ☐ Severe Swelling

Gastrointestinal:
- ☐ Abdominal problems
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Bloating
- ☐ Vomiting
- ☐ Indigestion/reflux

Other:
- ☐ Reaction to food
- ☐ Reaction to medicine
- ☐ Reaction to bee sting
- ☐ Chest pain
- ☐ Palpitations
- ☐ Urinary burning
- ☐ Frequent urination
- ☐ Joint pain/swelling
- ☐ Depression/anxiety
- ☐ Swollen glands
- ☐ Bleeding problems
- ☐ Recurrent infections
- ☐ Behavior problems
- ☐ Migraines

Do you have a Food Allergy Concern do you wish to have testing for food allergy?

Yes No

Please ***check the box*** for any therapy or surgery that the patient has ever taken for these symptoms:

- ☐ **No medicines tried yet**
- ☐ Benadryl
- ☐ Sudafed/Decongestants
- ☐ Zyrtec/Cetirizine
- ☐ Clartin/Loratadine
- ☐ Allegra/Fexofenadine
- ☐ Clarinex
- ☐ Xyzal/Levocetirizine
- ☐ Medicated eye drops
- ☐ Steroid nose sprays (Flonase, Fluticasone, Nasonex, Nasacort, Triamcinolone, Veramyst, Rhinocort, Omnaris, Qnasl, Zetonna)
- ☐ Antihistamine nose sprays (Astelin, Azalastine, Astepro, Patanase, Dymista)
- ☐ Albuterol Inhalers (Proair, Proventl, Maxair, Ventolin, Xopenex)
- ☐ Nebulizer (breathing machine) Albuterol or Xopenex
- ☐ Steroid Inhalers (Flovent, Asmanex, Pulmicort, Qvar, Alvesco, Advair, Symbicort, Dulera, Aerospan, Arnuity, Breo, Trelegy, Brezri)
- ☐ Nebulizer steroid (Pulmicort, Budesonide)
- ☐ Steroid shot/ pills/ liquid
- ☐ Singulair (montelukast)
- ☐ Steroid ointments or creams
- ☐ Allergy shots
- ☐ Afrin (oxymetazoline)
- ☐ Epipen/ Auvi-Q
- ☐ Antibiotics

Surgeries:
- ☐ Tonsils taken out
- ☐ Adenoids taken out
- ☐ Ear tubes
- ☐ Sinus surgery
- ☐ Deviated septum correction

Please list **ALL** medications that the patient is CURRENTLY taking: If you have a list of current medications, please provide us with your list.

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Please ***check the box*** for any other medical problems that a doctor has diagnosed the patient with:

- ☐ Asthma
- ☐ Low thyroid
- ☐ Chronic fatigue
- ☐ Colitis
- ☐ Autism spectrum
- ☐ Sleep Apnea
- ☐ Eczema
- ☐ Gastroesophageal reflux
- ☐ High blood pressure
- ☐ Emphysema or COPD
- ☐ Large tonsils or adenoids
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Migraines
- ☐ Lupus
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Osteoarthritis
- ☐ Anxiety
- ☐ Celiac disease
- ☐ Diabetes
- ☐ Sleep disorder
- ☐ Polycystic Ovaries
- ☐ High Cholesterol
- ☐ Arthritis
- ☐ Crohn's Disease
- ☐ Abnormal heartbeat
- ☐ ADHD or ADD
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Seizures
- ☐ Cerebral Palsy
- ☐ Cancer: what type(s) ____________

☐ Other: ____________________

Has the patient been hospitalized due to allergies? No ☐ Yes ☐ Please describe: ____________________

After a BEE STING, has the patient ever had a severe reaction? (difficulty breathing, wheezing, throat closing, passing out, hives or rash) **No** **Yes**

Does the patient have any known drug allergies? If so, please list:

____

Are there any close relatives of the patient with allergic disorders? If so, please check the box:

Mother:	☐ nasal/eye allergy	☐ asthma	☐ eczema	☐ food allergy	☐ other: ________
Father:	☐ nasal/eye allergy	☐ asthma	☐ eczema	☐ food allergy	☐ other: ________
Siblings:	☐ nasal/eye allergy	☐ asthma	☐ eczema	☐ food allergy	☐ other: ________
Children:	☐ nasal/eye allergy	☐ asthma	☐ eczema	☐ food allergy	☐ other: ________

What is the work environment for the patient: ☐ **In-person** ☐ **Hybrid** ☐ **Work from Home** ☐ **N/A**

At work, does the patient have exposure to fumes, dusts, air-born chemicals, glues, resins, or latex? ☐ **No** ☐ **Yes**

Does the patient attend a daycare? (child or adult) ☐ **No** ☐ **Yes**

The following questions refer to the residence or home where the patient spends the most time. Please circle the answer

- Is there any known mold damage? **No** **Yes** If yes, where? ____________
- How many beds are there in the patient's bedroom? 1 bed 2 beds 3 beds crib bunk beds
- Are the stuffed animals in the patient's bed? **No** **Yes**
- Are there currently, or have ever been, any dogs in the house? **No** **Yes** If yes, how many? ______
- Are there currently, or have ever been, any cats in the house? **No** **Yes** If yes, how many? ______
- Are there currently, or have ever been, any pets with fur or feathers in the house? **No** **Yes** If yes, what type? ______
- How much of the flooring is carpeted? None Less than half About half Most All
- What type of air conditioning do you have? None Window AC Central Air Conditioning
- What type of heating do you have? Forced air (furnace/heat pump) Radiators Fireplace Wood
- Is the patient currently a smoker? **No** **Yes**
  - If yes, how much does the patient smoke? ____ packs: per day per week
  - If no, what the patient a smoker in the past? **No** **Yes**
- Are there any smokers who live with the patient? **No** **Yes** If yes, how many? ______

Patient Name (**Print**): ____________________ Date: ________

Patient or Guardian Signature: ____________________