

DEVOE ALLERGY & ASTHMA CLINIC
Phillip W. DeVoe, M.D., PA

WELCOME TO DEVOE ALLERGY AND ASTHMA CLINIC

New Patient Instructions

Thank you for choosing DeVoe Allergy and Asthma Clinic for your health care needs. We strive to make your visit as pleasant as possible. Your first visit will require approximately **1-1/2 to 2 hours** of your time. Patients under 18 years of age must be accompanied by a parent or legal guardian. If accompanied by a legal guardian, custodial papers are required for treatment.

_____ appointment is scheduled for _____ at _____
am/pm.

Below is a checklist of what you need to bring to your first visit. Please call us before your appointment if you have any questions about what you need to bring.

- Complete the Patient History form (enclosed)
- Complete the Patient Information form (enclosed)
- Sign the Notices and Disclosures form (enclosed)
- Bring your Insurance card/s.
- Please bring or have your referring physician fax reports (sinus & chest X-rays, CT or MRI scans, and any relevant laboratory results) if you have had these done within the last 6 months.
- Please bring or have your referring physician fax any notes from other physician offices relating to the reason for your visit.
- Bring all immunization records for patients under 18 years of age.

In consideration of others, we request that you refrain from wearing any perfume, lotion, or cologne.

If you are unable to keep your appointment, please call our office at least 24 hours in advance at 321-951-2709.

We look forward to seeing you.
Sincerely,

Phillip W. DeVoe, MD

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Notices and Disclosures

HIPAA Disclosure. A copy of the DeVoe Allergy & Asthma Clinic (DAAC) Health Insurance Portability and Accountability Act (HIPAA) Policy regarding the privacy of personal health information is available to review on request at the front desk of the business or on the website, devoeallergy.com/forms. I acknowledge that I have been given an opportunity to read this policy.

Record Disclosure. I consent that as a courtesy to me, DAAC may, but is not required, to forward records relating to my visits to my referring physician, family physician, or primary care physician listed on my new patient information form, subject to administrative costs, such as photocopying and postage.

Primary and Emergency Care Disclosure. I understand that DAAC provides care for allergy and immunology in conjunction with primary care provided by other physicians. I further understand that Dr. DeVoe is not available to see patients for emergency care outside of normal office hours and that Dr. DeVoe will not be available to act as my physician at a hospital emergency facility. I agree to maintain a source of primary care and emergency care while receiving allergy services by Dr. DeVoe.

Insurance Coverage. I understand that it is ultimately my responsibility to determine whether my insurance covers medical services provided by DAAC. DAAC may submit insurance claims on my behalf. I agree to immediately pay any balance that is not paid by my insurance company. I further agree to pay the costs for collection, including but not limited to court costs and attorney’s fees, relating to my unpaid balances.

Fees. I understand there will be a \$25 fee for missed follow up appointments and a \$50 fee for missed in-office testing appointments. Please call our office at least 24 hours in advance to cancel or reschedule any further appointments to avoid fees at 321-951-2709. A full list of office fees is available upon your request.

Consent to Medical Records Photo. I consent that an electronic photograph of a patient receiving care at DAAC may be included as of the medical record and understand that it will not be used for any other purpose.

Consent for Communication. I grant permission for DAAC, and its employees and agents, to call me at the home and work numbers listed on my patient information form, as updated by me, and if appropriate, to leave messages on any associated answering machine or voicemail, with information relating to my medical care; including, without limitation appointment, billing, medical, and other information. I give DAAC permission to share any and all information relating to my medical care with the person(s) named below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I acknowledge that I have read, been advised of, and agree to the foregoing.

Patient Name (Print)

Patient or Guardian Signature

Date

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PATIENT NAME: _____

MALE FEMALE

(MR.MRS.MISS MS.): _____ NICKNAME: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME PHONE: () _____ WORK PHONE: () _____ CELL: () _____

WHICH IS THE BEST NUMBER TO CALL? ___ HOME; ___ WORK; ___ CELL

BIRTH DATE: _____ AGE: _____ SOCIAL SECURITY # _____

RACE/ ETHNICITY: (Pick One): ___ AMERICAN INDIAN; ___ ASIAN; ___ BLACK/AFRICAN AMERICAN; ___ EUROPEAN;
___ HISPANIC; ___ LATINO; ___ WHITE; ___ OTHER _____

LANGUAGE: ___ ENGLISH; ___ SPANISH; ___ OTHER _____

GUARDIAN/PARENT (IF CHILD) _____

EMAIL: _____ PHARMACY: _____ PHARMACY PH #: () _____

**If you are not the parent or legal guardian, you must have written permission from the parent or guardian to bring a child under the age of 18.*

NEAREST RELATIVE: _____ RELATIONSHIP: _____

HOME PHONE: () _____ WORK PHONE: () _____ CELL: () _____

PERSON RESPONSIBLE FOR PAYMENT:

NAME: _____ SOCIAL SECURITY #: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

BIRTH DATE: _____ RELATIONSHIP TO PATIENT: _____

REFERRING PHYSICIAN: _____ PHONE#: _____

FAMILY PHYSICIAN: _____ PHONE#: _____

PRIMARY INSURANCE INFORMATION: PLEASE PRESENT INSURANCE CARD(S) AT OFFICE VISIT

POLICY HOLDER'S NAME: _____ BIRTH DATE: _____

NAME OF PRIMARY INS. COMPANY: _____ PHONE#: _____

PRIMARY POLICY IDENTIFICATION#: _____ GROUP/PLAN#: _____

NAME OF LABORATORY _____ X-RAY FACILITY _____

SECONDARY INSURANCE INFORMATION:

NAME OF SECONDARY INS. POLICY HOLDER: _____ BIRTHDATE: _____

NAME OF SECONDARY INS. COMPANY: _____ PHONE#: _____

SECONDARY POLICY IDENTIFICATION#: _____ GROUP/PLAN#: _____

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries, or carriers for Medicare claims or to my insurance company or its representative, any information needed to process an insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefit either to myself or to the party who accepts assignment.

DATE: _____ SIGNATURE OF PATIENT/PARENT/GUARDIAN: _____

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HISTORY FOR AGES 18 AND OLDER

Name: _____ Date: _____

Describe the main reason for your visit:

COMMON ALLERGIC PROBLEMS

“X” any of the following that you think may be present:

Allergic Problem

- ASTHMA (recurrent wheezing or coughing)
- CHRONIC BRONCHITIS (chronic cough with mucus production)
- HAY FEVER (itching nose or eyes, stuffy or runny nose, frequent sneezing)
- SINUSITIS (infection of the sinuses and nose)
- HIVES (itchy bumps on the skin that come and go)
- ECZEMA (dry, itchy skin)
- FOOD REACTIONS
- MEDICATION REACTIONS
- INSECT STING REACTIONS
- FREQUENT INFECTIONS
- OTHER _____

ENVIRONMENT

If you have lived in another state other than Florida for a year or longer, list which states: _____

If you have traveled outside the US in the past year, list where: _____

HOME

How old is your home? _____

Is your home close to the beach in a suburban development in the city on a farm?

Do you have central heat and air? YES NO

Do you keep the windows open in nice weather? YES NO

Does your bedroom have hard surfaced floors carpeting?

Do you have a feather pillow or comforter? YES NO

Do you have any exposure to indoor pets? YES NO

If YES, list type of pet(s) _____

Do you do yard work? YES NO

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Name: _____

SMOKING HISTORY

Have you ever smoked? YES NO If yes, for how many years? _____
Number of packs per day _____
Do you still smoke? YES NO What year did you stop smoking? _____
Does anyone smoke in your home? YES NO

PAST MEDICAL HISTORY

Any emergency room visits during the past year? YES NO
Any hospitalizations? YES NO _____
Any surgeries? YES NO _____
Have you had a previous allergy evaluation? YES NO
If yes, did you have skin testing blood testing?
Allergies found _____
Have you had allergy shots? YES NO
Laboratory tests or x-rays during the past year? YES NO _____

FAMILY HISTORY:

Do any family members have the following?

- | | |
|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Immune deficiency |
| <input type="checkbox"/> Cystic fibrosis | |

SOCIAL HISTORY

Please check boxes which apply to you: Live alone Live with family Other: _____
Have you had any adverse food reactions? YES NO
Are you on a special diet? YES NO
What foods are avoided? _____
How many alcoholic drinks do you have each week? _____

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Name: _____

Do you have a regular exercise program? YES NO

If YES: Type of exercise: _____

Times per week: _____

Recent unusual stress? YES NO Type: _____

WORK

Retired Working At present job for _____ years.

Type of work (now or before retirement): _____

Any work-related air quality problems? YES NO

Number of days of work missed (approx) because of illness during the past 12 months: _____

X" symptoms present during the past year:

Unintentional weight loss	Constipation
Loss of appetite	Stomach ulcers
Unusual irritability	Liver problems
Unexplained fatigue	Loss of consciousness
Jaundice (yellowing of skin, eyes)	Seizures
Rash	Head or neck injury
Skin abcess	Frequent severe headaches
Changing appearance of a mole	Difficulty with concentration
Ear pain	Numbness or tingling of extremity
Ear drainage	Anxiety or depression
Decreased hearing	Memory loss
Eye pain	Excessive thirst
Worsening of vision	Hair loss
Redness of eyes	Thyroid problem
Hoarseness or loss of voice	Excessive weight gain
Nose bleeds	Poor tolerance of heat or cold
Loss of hearing	Diabetes
ringing in the ears	Recurrent Chills
Dizziness or loss of balance	Unexplained fever
Burning of the eyes	Meningitis
Glaucoma	Pneumonia
Chest pain	Joint infection
Snoring	Enlarged lymph nodes
Long pauses in breathing while asleep	Received blood transfusion
Feeling heart race or skip beats	Treatment for tuberculosis
Difficulty in taking a deep breath	Night sweats
Chest pressure	Anemia
Ankle swelling	Easily bruise
High blood pressure	Broken bones
Heart problems: _____	Joint swelling
Recurrent bronchitis	Joint pain
Chronic or persistent cough	Muscle weakness
Difficulty swallowing	Urinary tract infection
Stomach or abdominal pain	Kidney stones
Diarrhea	Prostate problems (males)
Vomiting	GYN problems (females)

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TRIGGERS

Have symptoms been present less than 1 year more than 1 year?

Symptoms are worse:

- Spring Summer Fall Winter No change with time of year
 Day time Nighttime Same any time of the day
 Indoors Outdoors Location does not affect symptoms

"X" those exposures below that cause nasal symptoms:

- Exercise..... Tobacco smoke
 Insecticides..... Foods.....
 Perfume or hair spray Changes in weather.....
 Wind Pets.....
 Freshly mowed grass

MEDICATIONS

Medications currently being used:

Medication	Dosage	Medication	Dosage

Please list all vitamins and supplements currently being used:

Please list any medications that you are unable to take due to reactions:

Medication	<u>Reaction</u>

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Name: _____

Please mark current symptoms

SYMPTOM	ABSENT	MILD	MODERATE	SEVERE
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GERD (acid in the throat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>