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 NEWBORN TO 4 YEARS OLD

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 the patient has lived in another state other than Florida for a year or longer, list which states: _____

If the patient has traveled outside the US in the past year, list where: _____

Does the patient attend daycare? ☐ YES ☐ NO

HOME:

How old is the patient's home? _____

Is the patient's home ☐ close to the beach ☐ in a suburban development ☐ in the city ☐ on a farm?

Does the patient have central heat and air? ☐ YES ☐ NO

Are windows kept open in nice weather? ☐ YES ☐ NO

Does the patient's bedroom have ☐ hard surfaced floors ☐ carpeting?

Does the patient have a feather pillow or comforter? ☐ YES ☐ NO

Does anyone smoke in the home? ☐ YES ☐ NO

Does the patient have any exposure to indoor pets? ☐ YES ☐ NO

Type of pet(s)? _____

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Name: _____

PAST MEDICAL HISTORY:

Any emergency room visits during the past year? ☐ YES ☐ NO

Any hospitalizations? ☐ YES ☐ NO

Any surgeries? ☐ YES ☐ NO

Has the patient had a previous allergy evaluation? ☐ YES ☐ NO

If yes, did the patient have ☐ skin testing ☐ blood testing?

Allergies found: _____

Laboratory tests or x-rays during the past year? ☐ YES ☐ NO

If YES: _____

BIRTH HISTORY:

Birth weight: _____

Check any problems that apply:

Needed oxygen as a newborn_____ Prematurity ____Jaundice _____Colic_ ____Croup_____

Hyperactivity _____Spitting after four months of age _____Developmental delay_____

Behavioral problems _____Learning disabilities_____

FAMILY HISTORY:

Do any family members have the following?

☐ Asthma
☐ Eczema
☐ Migraines
☐ Frequent infections
☐ Cystic fibrosis
☐ Hay fever
☐ Sinus problems
☐ Diabetes
☐ Immune deficiency

SOCIAL HISTORY:

Number of family members that are in the patient's home:

Mother _____ Father____ Sibling(s) _____ Other_____

Has the patient had any adverse food reactions? ☐ YES ☐ NO

Is patient on a special diet? ☐ YES ☐ NO

If "yes", what foods are avoided: _____

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Name:_____

"X" Symptoms present during the past year**:**

Failure to gain weight or weight loss		Vomiting	
Loss of appetite		Constipation	
Unusual irritability		Loss of consciousness	
Jaundice (yellowing of skin/eyes)		Behavior problems	
Rash		Shaking or tremors	
Skin abcess		Seizures	
Changing appearance of a mole		Too quiet or withdrawn	
Ear pain		Head or neck injury	
Ear drainage		Frequent severe headaches	
Decreased hearing		Excessive thirst	
Eye pain		Repeated colds or sinus infections	
Worsening of vision		Unexplained fever	
Redness of eyes		Meningitis	
Nose bleeds		Pneumonia	
Chest pain		Anemia	
Noisy breathing		Bruise easily	
Rapid breathing		Broken bones	
Heart murmur		Joint infection	
Snoring		Joint swelling	
Difficulty swallowing		Muscle weakness	
Stomach or abdominal pain		Urinary tract infections	
Diarrhea			

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

CURRENT MEDICATIONS:

Medications	Dosage	Medications	Dosage

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

Medication	Reaction

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Name:_____

Please mark current symptoms

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