Asthma & Allergy Physicians of RI, Inc.

New Patient Information Sheet

Full Name: ______________________________ Date of Birth: ___________ Gender: _________

Address: ________________________ City: _________________ State: ___ Zip Code: _______

Telephone: (Home) _______________ (Work)__________________ (Cell) ________________

Race: White____ Hispanic ____ Non-Hispanic ____ African American ____ Native American ____

Asian____ Other____________________ Prefer not to answer ____

Social Security: _____-____-_____ (required) Email address: ________________________________

Employed by: ______________________________ Spouse, Parent, Guardian Name: ____________________

Primary Care Physician: _____________________ Referring Physician: ________________________

Primary Insurance: _________________ ID: ______________ Effective Date: _______________

Insured's Name: __________________ Date of Birth: ____________ SSN# ______-____-_________

Secondary Insurance: _________________ ID: _______________ Effective Date: _______________

Secondary Insured's Name: ____________________ Date of Birth: ____________ SSN#___-___-_____

Insured's Employer (Primary): ___________________ Secondary: ____________________________

Emergency Contact: _______________________ Phone: ______________ Relationship: __________

I authorize AAPRI to forward progress reports to my PCP and/or referring providers as needed.
Yes _____ No_____ Initial __________

CONSENT FOR HEALTHCARE OF MINOR:

By signing below, I give consent for AAPRI to treat my son/daughter in the event that a parent or legal guardian is not able to accompany him/her to the appointment. This may include, but not necessarily be limited to: physical exams, skin testing, allergy injections and issuing prescriptions in my absence. This agreement will be in effect until revoked by me in writing.

Signature of Parent or Guardian:_____________________________ Date: _________________

BILLING PROCEDURE

This office participates with most insurance carriers in the state, as well as several carriers out of state. If you have health coverage with any of these carriers, we will automatically bill them for their contracted portion of your care. In most other situations we will provide you with a copy of your encounter form, which you may then submit to the carrier for reimbursement. This encounter form has the information required by most insurance companies. Your signature is required in all cases where we will be submitting on your behalf to the carrier.

Signature: ______________________________________ Date: _______________________

Asthma & Allergy Physicians of Rhode Island

Patient Name: ______________________________ Date of Birth: ___/___/______

Address: ____

City: ______________________________ State: _______ Zip: ____________________

Telephone- Home: _____________ Cell: ________________ Work: _________________

Today's Date: __________ Referring Physician, person or source:_____________________

Please answer the following questions as accurately as possible, since they will help us better assess your problem(s).

Please describe the reason for your visit today:

Have you ever been diagnosed with any of the following conditions?
(please circle the appropriate answer)

Asthma: Yes/ No If yes: Age of Onset: _____ Mild/ Moderate/ Severe

Breathing Problems: Yes/ No If yes: Age of Onset: _____ Mild/ Moderate/ Severe

Sinus Trouble: Yes/ No If yes: Age of Onset: _____ Mild/ Moderate/ Severe

Hay Fever: Yes/ No If yes: Age of Onset: _____ Mild/ Moderate/ Severe
(itchy eyes, runny or stuffy nose, sneezing)

Hives: Yes/ No If yes: Age of Onset: _____ Mild/ Moderate/ Severe

Eczema or Rashes: Yes/ No If yes: Age of Onset: _____ Mild/ Moderate/ Severe

Food Reactions: Yes/ No If yes: Age of Onset: _____ Mild/ Moderate/ Severe

If yes, describe incident: ____

Insect Bite Reactions: Yes/ No If yes: Age of Onset: _____ Mild/ Moderate/ Severe

Frequent Reactions: Yes/ No If yes: Age of Onset: _____ Mild/ Moderate/ Severe

If yes, describe problem: ____

Current Medications:

(Please list ALL *medications including any prescriptions, over-the-counter & Herbal treatments)*

Medication: ______________________________ Dose: ______________________

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Medication: ______________________________ Dose: ______________________

Medication: ______________________________ Dose: ______________________

Medication: ______________________________ Dose: ______________________

Previous Allergy Treatment:

Drug Allergies (describe reaction):

Past Medical History:

Hypertension: Yes ___ No____ Onset: ________________________________
Diabetes: Yes ___ No____ Onset: ________________________________
Heart Disease: Yes ___ No____ Onset:________________________________
Chronic Bronchitis/ Emphysema/ Pneumonia: Yes ___ No___ Onset: ______________________
Abdominal bloat: ____ Constipation: ____ Diarrhea: ____ Reflux/heartburn: _____

____

If yes, explain onset and current treatment plan above

Recent Hospitalization: Yes___ No ___ If yes, explain reason for visit, and dates you were there.

____

Have you had a recent chest X-ray or Sinus Imaging? Yes____ No ____
Family History:
Asthma: Yes__ No___ Hay fever: Yes___ No ___ Eczema: Yes___ No ___
Family History of Cancer: Yes___ No___ Types: ______________________________________
Have you ever smoked? Yes___ No___ If yes, how many years? ____________________
Do you presently smoke? Yes___ No ___ If yes, how many cigarettes daily? _______________
Do other members of your household smoke? Yes____ No____ Do they smoke indoors? Yes___ No___