ALLERGY, ASTHMA AND IMMUNOLOGY CARE CENTER	
LOUISE H. BETHEA, M.D.	**JAMES T. JAING, M.D.**

Date:

Patient's last name	First Name MI
Soc Sec #	Date of Birth Age M/F
Address:	Apt# Marital Status M S D W Sep
City	State Zip Code:
Home Tele#	Work Tele #:
Employer:	Occupation
Address	Suite
City:	State Zip Code:

Spouse Name	Home Tele #
Employer	Occupation SS#
Address	Suite
City	State Zip Wk #

MINOR PARENT / GUARDIAN INFORMATION	
Mother's (guardian)	Social security #
Address	Apt #
City	State Zip Code
Employer:	Occupation
Address	Suite Tele#
City	State: Zip Code:
Father's (guardian)	Social security #
Address	Suite: Tele #
City	State: Zip Code
Employer	Occupation:
Address	Suite: Telephone
City	State: Zip Code

DOES THE PATIENT LIVE WIITH BOTH PARENT? YES OR NO IF NO SPECIFY:

In case of emergency contact:	
Name:	Relationship to patient:
Telephone	Alternate#
Name:	Relationship to patient:
Telephone	Alternate#

Who referred you to our practice	
Name of primary care physician	
Address Suite	City
State: Zip	Tele #

INSURANCE INFORMATION	Employer
Name of policy holder	Date of Birth: SS#
Name of Insurance	Group or policy#
City	State Zip
Do you require a referral from primary care doctor?	Yes or No
Did you bring your referral with you?	Yes or No

CREDIT POLICY:
We hope you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this vital health care facility for our patients and our community.

Charges for medical services at our office are due and payable at this time services are rendered. If you cannot make the payment in full at the time of service, a substantial down payment is expected. Please make these arrangements in advance with the office manager.

INSURANCE INFORMATION:
If at any time your insurance plan changes, it is your responsibility to make the office staff aware of this by calling, faxing a copy, or bringing the new insurance card to our office within 24 hours prior to an appointment or any procedure. If this is not done, you may be held responsible for the charges not paid by your insurance company.

If you have a problem with our office or staff, please feel free to ask for the office manager and I will help in any way to help resolve the problem.

I hereby authorize Louise H. Bethea, M.D. or James T. Jaing, M.D. to appeal on my behalf my claim(s) with _____, if applicable, and/or any payor, which denies and/or delays payment of my claim(s). I further authorize that the payors, listed herein and any other payors, release any and all information requested and/or related to my claim(s) to the physicians: Louise H. Bethea, M.D. or/ James T. Jaing, M.D./and or its attorneys. This authorization is irrevocable upon execution by my hereinbelow and any appeal brought by the physicians shall be as if it was brought by me personally.

I hereby authorize the physician(s) to furnish information to the insurance carrier concerning this illness/accident, and I hereby irrevocably assign to the physician(s) all payments for medical services rendered I understand that I am financially responsible for all charges whether or not covered by my insurance. I hereby transfer all title and interest in any monetary insurance benefits to my physician(s).

_____ _____

Signature of responsible party Date

ALLERGY QUESTIONNAIRE

Instructions: Carefully complete in full. Accuracy and thoroughness is essential. Print all answers. Relate answers to your own experiences, not to previous advice on skin tests. This form must be completed prior to seeing the physician.

ALL INFORMATION IS CONSIDERED CONFIDENTIAL.

Date:_____Name:_____
Phone#: _____
Address:_____City:_____State:_____
Zip:_____
Birth date:_____ Sex:_____
Race:_____
Employer:_____
Occupation:_____ Work Phone#:_____
Name of Referring Physician: _____
Phone#:_____
Address of Referring Physician:_____

State problem(s) you wish to discuss:
_____
_____
_____
_____
When did it begin?_____ How often does it occur?_____
Worse at: day or night. How long does it last? _____
Circle months most severe: Jan. Feb. March April May June July Aug. Sept. Oct. Nov. Dec. All Year
What do you think makes it better?_____
What do you think makes it worse?_____
What do you think causes the problem?_____
_____

Circle Terms That Affect Your Problem

Irritants: cleanser, detergent, cooking odor, perfume, powder, tobacco smoke, other smoke:_____ moth balls, motor fumes, paint lacquer, wax, glue, insect spray, fertilizers, ammonia, room deodorants, chemicals, bleach, other:_____

Toiletries: soap, shampoo, shaving cream, after-shave, spray deodorant, hair spray, hair tonic, hair dye, hand cream, make-up, toothpaste, denture cream, mouthwash, nail polish, other: _____

Foods: milk, cheese, eggs, fish, shellfish, nuts, chocolate, alcohol, wine, beer, juices, spices, vegetables, strawberries, wheat products, very cold liquids, other:_____

Pets: Which of these do you have as pets? dog, cat, bird, horse, hamster, rabbit, _____. Is your condition worse around pets? Please specify):_____

Drug Allergies: penicillin, sulfa, aspirin, over the counter drugs, other:_____

Weather: hot, cold, humid, damp, pollution, smog, sunlight, air-conditioning, change in temperature.

New Clothing: Clothing which has not been yet washed: wool, silk, sweater, coat, shoes, dry-cleaned clothes, starched clothes, other:_____

Contactants: poison ivy, cut grass, cut flowers, household plants, hay, Christmas trees, plastic, fiberglass, rubber, dust, wool blankets, feather pillows, mattress, overstuffed furniture, rugs, rug pads, stuffed toys, furs, jewelry, shoe polish, other:_____

Circle Symptoms Brought On By Your Problem(s)

General: nervousness, dizziness, fainting, sinus trouble, frequent colds, fatigue, other:_____

Headache: Where? (front, back, right, left). Day, night, aching, throbbing, sharp, dull, with vomiting, stuffy nose, better with sleep, worse with tension, spots before eyes. Cause: migraine, food, sinus tension, drug, other:_____

Skin: rash, hives, eczema, blisters, itching, swelling, burning, stinging, redness, perspiration, dandruff, athlete's foot. Where? _____ Worse after eating? Yes or No

Eyes: tearing, burning, itching, pain, redness, discharge, puffiness, infections, blurring of vision, glaucoma, other:_____

Ears: pressure, itchiness, drainage, bleeding, infections, deafness, swelling, other:_____

Nose: trouble smelling, stuffiness, sniffles, itching, sneezing, snoring, polyps, post-nasal drip, picking, bleeding, broken nose, previous surgery, other:_____

Tongue: swollen, sore, itching, coated, trouble tasting, other:_____

Mouth: itching of roof, repeated tonsillitis, tonsils removed, morning sore throats, bad breath, swollen lip, trouble swallowing, mouth breathing, frequent throat clearing, change in voice other:_____

Mucus: thick, thin, clear, yellow, green, brown, bloody. Amount per day: (teaspoon, tablespoon, 1/2 cup) Source of mucus: (nose, lungs, throat)

Chest: shortness of breath, wheeze, pain, tightness, cough, cough then wheeze, trouble walking, trouble working, trouble sleeping, heart trouble, high blood pressure, emphysema, bronchitis, pneumonia, tuberculosis, cancer, other:_____

Stomach: vomiting, cramps, belching, acid indigestion, other:_____

Bowels: diarrhea, gas, mucus in stool, blood in stool, foul-smelling stool, other:_____
Soiling: *Worse after eating what foods?*_____

Joints: pains, stiffness, swelling, other:_____

Menses: *(Females only)*: regular, irregular, discharge, itch, cramps, infections, pain. *Last period:*_____
Are you now pregnant? Yes_____ No_____
Are you taking birth control pills? Yes_____ No_____

Urine: pain, burning, frequent urination, bladder infection, recurrent infection, itching, chills, fever, other:_____

Circle Pertinent Items and Fill In The Blanks

1. Where do you live? room, apartment, brick house, wood-frame house, mobile home
*Age of house or home?*_____*(Years)*

2. *Location:* city, suburbs, country, farm, seashore, desert, mountains, near a factory, bakery, grain storage, swamp, poultry yard, barn, other:_____

3. *Problems worse in:* bedroom, living room, kitchen, basement, attic, garage, indoors, outdoors, other:_____

4. *Type of heating:* forced air, radiator, electric, heat pump, filtered air, other:_____

5. *Where is it worse:* List the states or geographical areas:_____
_____

6. *Problem(s) worse when:* at home, at work, in car, in boat, exercising, at beauty shop, at school, driving in traffic, sweeping, house cleaning, making beds, around fans, around humidifier, around vaporizer, around open windows, around heating ducts, on windy days, taking hot or cold baths, swimming in chlorinated water, in musty places, wearing tight clothing, other:_____

7. *Insect bites or stings:* more than average, large swelling weakness, sweating, shortness of breath, stuffy nose, sneezing, other:_____

8. *Recent dental work:* fillings, caps, root canal, tooth extraction, braces, Novocain, cleaning, gum surgery, pyorrhea, bridge, denture, other:_____

9. *Marital status:* (Parents' status, if parent is a child): married, single, separated, divorced, widowed
Number of children: 1, 2, 3, 4, 5, more _____

10. *Education:* Circle highest grade completed: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, College: 1, 2, 3, 4, Other:_____

11. *Smoking habits:* Circle: cigarettes, cigars, pipe. Inhale?:Yes____No____
Number per day?:_____How Long?:_____
(Years)

12. *Medications Now Using:* *Times Used Per Day:*
_____
_____
_____
_____
_____
_____
_____
_____

13. *Drugs:* alcohol, marijuana, crack/cocaine, heroin, other:_____
How much and how often?:_____

14. *Childhood:* breast fed, bottle fed, colic, spitting up, gas, croup, hives, eczema, hay fever, frequent colds, migraine, sinus trouble, earaches, tonsillitis, dizziness, asthma, bronchitis, pleurisy, pneumonia, other:_____

15. *Immunizations:* Circle any you have ever had & describe any reaction you may have had.

SHOT:	REACTION:	SHOT:	REACTION:_____
Diphtheria	_____	Measles	_____
Tetanus	_____	German measles	_____
Whooping Cough	_____	Mumps	_____
Polio	_____	Influenza	_____
Smallpox	_____	Other	_____

16. *How would you describe yourself?* timid, quiet, aggressive, forward, shy, unfriendly, extrovert, depressed, tense, calm, relaxed, many friends, anxious, dependent, introvert, few friends, independent, bustling, happy, well-adjusted, other:_____

17. *Place the age of the family having any of the following condition in the appropriate area:*

Family Illness	Father	Mother	Brothers	Sisters	Children	Other Blood Relatives
Migraine	_____	_____	_____	_____	_____	_____
Hives	_____	_____	_____	_____	_____	_____
Emphysema	_____	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____	_____
Cystic Fibrosis	_____	_____	_____	_____	_____	_____
Eczema	_____	_____	_____	_____	_____	_____
Hay Fever	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____

18. *Hobbies:*

Husband: Wife: Children: Others At Home:

_____

_____

_____

_____

19. *Seriousness of problem has caused:* absence from work, absence from school, inability to sleep,inability to exercise, loss of appetite, nervousness, other:_____

20. *Unusual activities engaged in just prior to onset of symptoms:*_____

_____

21. *Unusual food or drink just prior to onset of symptoms:*_____

_____

22. *New environmental factors at home or at work:*_____

_____

23. *Emotional factors:* tension, worry, trouble sleeping, financial problems, marital problems, family problems, problems at work, fatigue, cry easily, depression, sexual problems, other:_____

24. *List any medical conditions for which you have been treated:*_____

_____

25. *List any surgeries you have had:*

Type Of Procedure:	Date or Year:
_____	_____
_____	_____
_____	_____
_____	_____

26. *List any other conditions for which you are currently being evaluated or treated for:*_____

_____

_____