ANTHONY
MEDICAL & CHIROPRACTIC CENTER

PATIENT HEALTH HISTORY

Patient Name: _____

Pharmacy Preference (include location):_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION?_____Yes_____No. If yes, please list below:

Name of Medication	Type of Reaction

DO YOU HAVE ANY FOOD ALLERGIES?_____Yes_____No. If yes, please list below:

Name of Food	Type of Reaction

HAVE YOU BEEN ALLERGY TESTED BEFORE?_____Yes_____No. If so, when? _____

DO YOU FEEL WORSE AT ANY TIME OF THE YEAR?_____Yes_____No. If yes, please explain below:

_____

HAVE YOU *EVER* HAD ANY SIGNS OF A SYSTEMIC ALLERGIC REACTION SUCH AS HIVES, CHEST TIGHTNESS, AND/OR SWELLING OF THE FACE? IF SO, WHEN? _____

ARE YOU PREGNANT, OR IS THERE ANY CHANCE YOU MIGHT BE PREGNANT?_____Yes_____No

WHEN WAS YOUR LAST MENSTRUAL CYCLE? _____

Sino-Nasal Outcome Test

Name: _____ Date: _____

1. Circle the answer that fits best for each Row

2. Then put a √ in the last column for the 5 most important items to you

	No Problem	Very Mild Problem	Mild or slight problem	Moderate problem	Severe Problem	Problem as bad as it can be	Most important 5 items
1. Need to blow nose	0	1	2	3	4	5	
2. Sneezing	0	1	2	3	4	5	
3. Runny nose	0	1	2	3	4	5	
4. Cough	0	1	2	3	4	5	
5. Post nasal discharge (dripping at the back of your nose)	0	1	2	3	4	5	
6. Thick nasal discharge	0	1	2	3	4	5	
7. Ear fullness	0	1	2	3	4	5	
8. Dizziness	0	1	2	3	4	5	
9. Ear pain/pressure	0	1	2	3	4	5	
10. Facial pain/pressure	0	1	2	3	4	5	
11. Difficulty falling asleep	0	1	2	3	4	5	
12. Waking up at night	0	1	2	3	4	5	
13. Lack of a good night's sleep	0	1	2	3	4	5	
14. Waking up tired	0	1	2	3	4	5	
15. Fatigue during the day	0	1	2	3	4	5	
16. Reduced productivity	0	1	2	3	4	5	
17. Reduced concentration	0	1	2	3	4	5	
18. Frustrated/restless/irritable	0	1	2	3	4	5	
19. Sad	0	1	2	3	4	5	
20. Embarrassed	0	1	2	3	4	5	
21. Sense of taste/smell	0	1	2	3	4	5	
22. Blockage/congestion of nose	0	1	2	3	4	5	
TOTAL							

Acknowledgement / Consent for Treatment

PATIENT NAME: _____ (Please print)

____ (initial) **RECEIPT OF *NOTICE OF PRIVACY PRACTICES***

I have reviewed a copy of Anthony Medical & Chiropractic Center Notice ***of Privacy Practice,*** which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____ (initial) **CONSENT TO TREATMENT**

I consent to the performance of examinations, diagnostic procedures, and rendering of treatment by the medical provider at Anthony Medical & Chiropractic Center and their designated medical office staff as is deemed necessary in the medical provider's judgment. I agree to be financially responsible for the costs of such diagnostic procedures. I authorize and consent to the disposal of materials and substances that would normally be removed in the course of such diagnostic procedures and medical treatment. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatments or examination at Anthony Medical & Chiropractic Center. ***I understand that I have the right to refuse any medical or surgical treatment that I do not want.***

____ (initial) **FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, HSA/HRA, AND AUTHORIZATIONS**

I understand that ***copays, deductibles/co-insurance will be collected at the time service.*** I further **understand** that I am financially responsible for all charges, and as a courtesy, my charges will be filed with my insurance carrier. I understand that my insurance may process certain services

I authorize the release of any medical information (including diagnosis and test results that may include drug and/or alcohol, psychological conditions, or Acquired Immune Deficiency Syndrome) necessary to process an insurance claim on my behalf. I request that my medical insurance carrier make payment directly to Anthony Medical & Chiropractic Center for services rendered to me. I understand I will be responsible for these charges if the claim is denied, is not paid in a timely manner, or the charges are not covered by my insurance.

HSA/HRA ACCTS: I understand my charges will be billed directly to my insurance company for processing of my claim, per my benefits. If at that point, a balance is due, I will receive a statement via mail for payment. I am aware that my insurance will be billed for services received at Anthony Medical & Chiropractic Center. I understand that I may or may not be responsible for out of pocket costs for treatment with Anthony Medical & Chiropractic Center, and that payment is due upon receipt of statement.

HMO Patients: I understand, if a referral from my Primary Care Physician is required, ***I am responsible*** for obtaining referrals prior to receiving treatment from Anthony Medical & Chiropractic Center. If said referral is not on file with Anthony Medical & Chiropractic Center at the time of my visit, and I choose to proceed with treatment, I understand I am responsible for all charges incurred during that visit, payable at the time of service.

Should my account become a collection problem, I understand I will be financially responsible for any additional fees incurred during the collection process. ***I also understand that all past due accounts must be paid in full prior to making any future appointments.***

My signature below indicates that I have read and am in agreement with all statements that I have initialed above.

_____ _____

(Signature of Patient/Parent/Guardian) **Date**

_____

Print Parent/Guardian Name & Relationship

Patient Registration

Name (Last, First, Middle):		Social Security Number:	
Parent/Guardian:	Relationship:	Cell Phone:_____ Other Phone:_____	
Address:	City:	State:	Zip:
DOB:	Sex: Male / Female	Marital Status: Single / Married / Divorced / Separated / Widowed	
Email Address:	Ethnicity: Hispanic/Other: _____ Race: White/Indian/Asian/African American:		
Emergency Contact:	Relationship:	Phone #:	
Pharmacy:		**Location:**	
Name of Referring Doctor:	Name of Primary Care Doctor: Phone:	Place of Employment:	

Health Insurance Information

Guarantor/Responsible Party: (Last, First, Mid):		DOB:	SSN:
Address/ City, State, Zip:	Relationship to Patient: Self/ Spouse/ Child:	Phone:	
Primary Insurance Name:	ID#:	Group#:	Phone#:
Subscriber/Employee's Name:	Relationship to insured: Self / Spouse / Child	DOB:	SSN:
Secondary Insurance Name:	ID#:	Group#:	Phone#:
Subscriber/Employee's Name:	Relationship to insured: Self / Spouse / Child	DOB:	SSN:

Referral Information (please circle):

Dr. Referral:	Another Patient:	TV	Radio
Internet	Google	Walk in	Other:_____
Staff:	Family, Friend:	Insurance	Promo Tool

How would you like to be contacted? Email ( ) phone ( ) text ( )

Patient Signature (If a minor/Parent, Guardian Signature) **Date**

Patient Record of Disclosures (PHI)

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential information of their protected health information (PHI) be sent to an alternate address. The HIPAA privacy rule is **federal law** and applies to all healthcare facilities, i.e. doctor's offices, hospitals, clinics, etc.

I authorize Anthony Medical & Chiropractic Center to disclose my protected health information (PHI) in the following manner: (please check all that apply)

( ) Leave message with detailed information; phone number: _____

( ) Leave a call back number only

( ) Written Communication (Example: prescriptions, laboratory results, receipts, etc.)

( ) Mail to my home or alternate address:

_____

_____

I authorize Anthony Medical & Chiropractic Center to share my protected health information (PHI) with the following: (check all that apply)

( ) Spouse (Name) _____ (

) Parents' (Name(s)) _____

( ) Caretaker (Name) _____

( ) Other – Specify: _____

( ) Primary Care Physician:_____Phone Number: _____

The HIPAA Privacy Rule generally requires providers to take reasonable steps to limit the use/disclosure of your protected health information (PHI). These provisions do not apply to uses or disclosures authorized by the individual in writing. NOTE: Uses and disclosures for treatment records, payment information and healthcare operations may be permitted without prior consent in an emergency.

Patient Name: _____

Patient's Signature: _____Date _____

Allergy Skin Testing Appointment

Full Skin Testing requires one appointment lasting approximately 90 minutes. Your skin testing appointment includes an in depth environmental allergy consultation and a thorough overview of an immunology program.

Please restrict exercising/strenuous activity two (2) hours prior to testing. If testing is positive, you will need to refrain from exercising/strenuous activity for the rest of the day.

Appointment Date-Skin Testing: _____Time: _____

See Medication Information (attached) that must be stopped 5 days prior to testing.

Please wear a comfortable, short sleeve shirt that can be rolled up to expose your arms easily.

Please Note: Your safety is our first concern. Patients must remain in the healthcare provider's office for **at least 30 minutes after all testing is completed**, sometimes longer waits are needed as directed by the healthcare provider. Please allot ample time for allergy testing when scheduling your consultation.

Medications To Be Avoided 5 days Prior to Skin Testing

Multi-vitamins, herbal treatments, fish oil & mineral replacements will need to be ***discontinued 5 days before testing***. If you are on **Monoamine Oxidase (MAO) inhibitors**, please check with your provider if you should stop them before testing. *Some medications may prevent patients from being eligible for skin testing-please check with your provider, (Beta Blockers).*

- Acebutolol
- Acrivastine (*Semprex-D*)
- Actifed
- Advil (*PM, Allergy, or Multi-Symptom Cold*)
- Allrest
- Alka-Seltzer (*Plus Cold, Flu*)
- Anafranil (*Clomipramine*)
- Axid (*Nizatidine*)
- Azelastine/Fluticasone nasal spray (*Dymista/ Astelin*)
- Brompheniramine (*Dimetane*)
- Carbinoxamine (*Palgic*)
- Cetirizine (*Zyrtec & OTC generic s*)
- Chlorpheniramine (*Chlor-Trimeton, Atrohist, Deconamine, Rondec, Rynatan)*
- Bystolic (*Nebivolol*)
- Clemastine (*Tavist*)
- Comtrex
- Contac
- Coricidin
- Cyproheptadine (*Periactin*)
- Desloratadine (*Clarinex*)
- Dimenhydrinate (*Dramamine*)
- Dimetapp
- Diphenhydramine (*Benadryl*)
- Doxylamine
- Dristan tablets
- Drixoral
- Elavil (*Amitriptyline*)
- Esmolol
- Fexofenadine (*Allegra*)
- Hydroxyzine (*Atarax, Vistaril*)
- Ketotifen tablets
- Levocetirizine (*Xyzal*)
- Loratadine (*Claritin, Alavert, OTC generics*)
- Meclizine (*Bonine*)
- Norpramin (Desipramine)
- Nyquil
- Olopatadine nasal spray (*Patanase*)
- Pamelor (*Nortriptyline*)
- Pepcid
- Phenindamine (*Nolahist*)
- Pheniramine
- Promethazine (*Phenergan*)
- Robitussin (*Cough/Cold, Cough/Allergy*)
- Sinequan (*Doxepin*)
- Sominex
- Sudafed (*Allergy, Severe Cold, Nighttime*)
- Tagamet
- Tenormin (*Atenolol*)
- Theraflu products
- Tofranil (*Imipramine*)
- Toprol XL/Lopressor (*Metoprolol*)
- Trazadone (*48hrs prior*)
- Triaminic
- Tripelennamine (*PBZ*)
- Triprolidine (*Triafed)*
- Tylenol (*Plus, Cold, Allergy, PM or Nighttime products*)
- Unisom
- Zantac- (*Ranitidine*)
- Zicam (*Cold & Flu)*

Also, any Over the Counter Allergy, Cold, Sleep Medications; Beta Blockers; and any Antihistamines. If you are taking any Anti-Depressants or Glaucoma medications, please call the office to speak with our nurse.

Common medications that you can continue to take:

Asthma Inhalers: Albuterol, Aerobid, Flovent, Pulmicort, Proventil, Ventolin, Azmacort, Advair, Maxair, Tilade, Brethair, Intal, Serevant, Foradil, QV A R

Nasal Sprays: Flonase, Beconase, Rhinocort, Nasalide, Nasonex, Nasarel, Atrovent, Nasonex, Rhinocort, Veramyst, Nasal Chrom, Atrovent

Anti-inflammatory: Advil, Tylenol, Aleve, Asprin, Alka Selzer (not Cold and Sinus or PM)

Sinus and Allergy: Singulair, Mucinex, Plain Sudafed **Antidepressants**: Lexapro, Paxil, Prozac, Zoloft, Celexa **Acid Reflux**: Nexium, Prilosec, Protonix, Aciphex

WHEN IN DOUBT, PLEASE CALL THE OFFICE AT 1-254-899-2225