CHISHOLM TRAIL ALLERGY AND ASTHMA
7200 DUTCH BRANCH ROAD, SUITE 200, FORT WORTH, TX 76132
PHONE (817) 346-7676/FAX (817) 346-7779
WWW.POLLENTRAIL.COM

New Patient Registration and Medical History

If the patient is a minor, please fill out as the patient. Today's Date: _____

Patient Name: _____Nick Name: _____

Address: _____ Apt/Lot: _____City: _____ State: _____ Zip Code: _____

Home Phone: _____Cell phone: _____ Email: _____

Is it ok to leave messages on the phone numbers listed? YES NO **Is it ok to send text messages? YES NO**

Date of Birth: _____ Sex: M / F Marital Status: Single Married Divorced

Employer and Occupation: _____ wk #: _____

Name of Patient's Spouse/Partner: _____ Phone # _____

May we speak to your spouse/partner regarding your care: Yes No

If MINOR please list school/daycare: _____ Grade: _____

If your child is a minor or if you are over 18 and would like to give consent to speak to your parents, please fill out parent information:

Mother's Name: _____ Phone # _____ Email: _____

Father's Name: _____ Phone # _____Email: _____

Is it ok to leave messages on the phone numbers listed? YES NO **Is it ok to send text messages? YES NO**

Referring physician: _____ Phone #_____

Primary care physician: _____ Phone # _____

How did you hear of our practice?

☐ Friend ☐ Relative ☐ Internet listing: _____ ☐ Primary care doctor ☐ Referring doctor ☐ Other: _____

PAYMENT AND INSURANCE INFORMATION **Financially responsible party**

To whom should the bill(s) be sent: SELF

Name: _____ Relationship: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip code: _____ Phone #: _____

Please note that we will need to copy your ID and insurance card(s).

Primary Insurance

Insurance name: _____ Member ID#: _____ Group name: _____Group/Plan#: _____

Subscriber name: _____ Relationship: _____ Subscriber DOB: _____

Secondary Insurance

Insurance name: _____ Member ID#: _____ Group name: _____ Group/Plan #: _____

Subscriber name: _____ Relationship: _____ DOB: _____

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Please sign giving us permission to access your prescriptions from your pharmacy: _____

Preferred Pharmacy name: _____ phone #/street off _____

Mail order pharmacy name: _____ phone # _____

What is the reason for your visit today: _____

Please fill out as the patient being seen (if patient is a minor, please answer questions 2 and 5)

1. Do you smoke or vap? No Yes How long? _____ How many packs per wk: _____
2. Anyone in your household smoke? No Yes
3. Do you drink alcohol? No Yes How many drinks a day? _____ Social _____ Occasional _____
4. Do you use sedatives or pain medications? No Yes Which medications_____ How often _____
5. Do you have pets? No Yes How many? _____ Cat Dog Bird Other: _____ Indoor _____ Outdoor_____

ALLERGY AND ASTHMA HISTORY **If yes, please answer the questions below:**

Have you ever been diagnosed with asthma: No Yes At what age? _____

Any hospitalizations for asthma? When? _____

Any ER visits for asthma? When? _____

Any oral steroids (prednisone) for asthma? When? _____

Have you ever had allergy testing before? No Yes When? _____

Please circle if Labs Skin Test By whom? _____

Were you on allergy shots? Yes _____ No _____ How long were you on allergy shots? _____

Have you ever been diagnosed with eczema? No Yes Do you see a dermatologist? _____

Have you had adverse reactions to foods? No Yes Please describe food & reaction _____

When did this happen? _____

Have you had adverse reactions to medications? No Yes Please describe medicine & reaction _____

When did this happen? _____

Have you had adverse reactions to bee, wasp, or fire ant? No Yes Please describe reaction _____

When did this happen? _____

Have you had adverse reactions to latex? No Yes Please describe reaction. _____

When did this happen? _____

PAST MEDICAL HISTORY Please indicate if you have, or are being treated for, any of the following:

	Yes	No		Yes	No		Yes	No
Cataracts			Thyroid disease			Sleep apnea		
Glaucoma			Lupus			GERD (heartburn)		
Osteoporosis			Rheumatoid arthritis			Headache/Migraine		
Anemia			Celiac disease			Nasal polyps		
Diabetes Type I/Type II			Psoriasis			Sinus infections		
Heart disease			Anxiety			Ear infections		
High blood pressure			Depression			Pneumonia		
High cholesterol			Cancer (type):			COPD(emphysema)		

HOSPITALIZATION HISTORY (Please list all hospitalizations due to asthma/allergic reaction you have had, within the last year and reason)

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SURGICAL HISTORY Please indicate if you have had any of the following procedures, and specify the year:

	Yes	No	When:		Yes	No	When:
Tonsillectomy				Sinus surgery			
Adenoidectomy				Nasal surgery			
Ear tubes				Nasal polyp surgery			

FAMILY HISTORY # of Siblings (the patient has) _____ or # of Children (the patient has) _____

Please let us know if Parents/siblings/children have been diagnosed with any of these conditions? Please check next to each box.

	Parents	Siblings	Children		Parents	Siblings	Children
Asthma				Cataracts			
Allergic rhinitis/hay fever				Glaucoma			
Eczema				Thyroid disease			
Food allergies				Lupus			
Celiac disease				Rheumatoid arthritis			
Urticaria (hives)				Cancer type?			
Angiodema (swelling)				Diabetes type?			
COPD/Emphysema				Hypertension			
Osteoporosis				High cholesterol			

MEDICATIONS

Please list your current medications and doses.

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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ASSIGNEMENT AND RELEASE

AGREEMENT TO PAY: In consideration for the services rendered and to be rendered by Chisholm Trail Allergy and Asthma to the patient, I (we) agree to pay Chisholm Trail Allergy and Asthma for all services and charges as are ordered by the attending physician in accordance with the terms and policies of Chisholm Trail Allergy and Asthma. If the services are not covered by private or government insurance, I (we) agree to pay Chisholm Trail Allergy and Asthma its standard non-discounted rate for the services provided. I (we) understand that Chisholm Trail Allergy and Asthma will make available to me (us) upon request a schedule of the standard charges for its services. I (we) further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made, to pay collection costs, including court costs, reasonable attorney fees and interest from the date of demand, if this account is placed for collection. Also, I (we) hereby acknowledge that Chisholm Trail Allergy and Asthma cannot assume responsibility for money, clothing, bridgework, dentures, eyeglasses, jewelry, credit cards, or any other personal items kept in my possession.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign to Chisholm Trail Allergy and Asthma and the attending physician, treatment expenses and benefits which are due or to be due to me as a result of medical services to the patient listed below. I hereby authorize the payments to be paid directly to Chisholm Trail Allergy and Asthma for any services furnished by the physician. I understand that I am responsible to Chisholm Trail Allergy and Asthma for payments made directly to me and any services or charges not covered by my insurance carrier.

CONSENT TO TREATMENT: I hereby voluntarily consent to medical care to include diagnostic procedures and medical treatment judged necessary by my physician. I acknowledge that no guarantees have been made to me as a result of this treatment. In addition to all other consents given elsewhere in this document, I specifically consent to medical procedures and tests necessarily performed upon me to aid and assist in the diagnosis and treatment of my child.

REASLEASE OF MEDICAL RECORDS: I hereby authorize Chisholm Trail Allergy and Asthma and all physicians involved with my care to release information from my medical records as may be required to any person, corporation or agency which is legally responsible or which Chisholm Allergy and Asthma has good cause to believe is legally responsible, for processing and/or paying all or any part of Chisholm Trail Allergy and Asthma's charges and/or professional fees; and, to any entity which has contracted with any insurer to conduct utilization or performance review. I hereby authorize Chisholm Trail Allergy and Asthma, or any physician involved with my care to release information to any physician or health care facility to which I may be transferred for further medical care.

_____ Date: _____

Signature of Patient (Parent/Guardian for minor)

_____ Date: _____

Witness (Employee of Chisholm Trail Allergy and Asthma)