PHILIP L. PASTERNAK, M.D.

F.A.A.P., F.AC.A.A.I, F.A.A.A.A.IALLERGY * ASTHMA * SINUS

REGISTRATION FORM

PATIENT INFORMATION

Last Name: ______________________ MI: _____ Home Phone#: ______________________

First Name: ______________________ Work #: ______________________

Street Address: ______________________ Date of Birth: ______________________

City/State: ______________________ Social Sec. #: ______________________

Zip Code: ____________ Gender (M/F) ______ Martial Status: S___ M___ D___ O___

Employer/School ______________________ Cell#: ______________________

Email: (optional) ______________________

Primary Dr. Name, address & Tel# ______________________

____

Referring Dr.'s name, address & Tel# ______________________

____

Insurance: ____________ Policy# ____________ Copay ____________

POLICY OWNER, IF DIFFERENT FROM PATIENT

Last Name: ______________________ First Name: ______________________

Date of Birth: ______________________ Home#: ______________________

Relation to Patient: ______________________ Social Sec. # ______________________

Address: ______________________

Employer: ______________________ Work/Cell#: ______________________

PERSON TO BE BILLED, IF DIFFERENT FROM PATIENT

Last Name: ______________________ First Name: ______________________

Date of Birth: ______________________ Home# ______________________

Relation to Patient: ______________________ Social Sec. # ______________________

Address: ______________________

Employer: ______________________ Work/Cell#: ______________________

PAGE MUST BE FILLED OUT AND SIGNED, THANK YOU

Patient/Guarantor Signature ______________________

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PRACTICE LIMITED TO ALLERGY

ALLERGY HISTORY

Date______________

NAME:______________________________ **DOB**__________________

Your Occupation__________________ **Prominent materials used at work**____________________

WHAT ARE YOUR PRESENT SYMPTOMS OF ALLERGY AND OR ASTHMA?__________________

____

____

Symptoms occur: all year spring summer fall winter other

What makes your symptoms worse?____

What makes your symptoms better?____

What medications have you tried for these symptoms?______________________________

In the Past Year: How many times have you visited the Emergency Room? __________**How many times have you used Prednisone or Prelone?** __________________**How Many times have you used your rescue Inhaler?** ______________________________

WHAT MEDICATION, INCLUDING NON-PRESCRIPTION MEDICATIONS, DO YOU TAKE DAILY OR FREQUENTLY?
Please circle if applicable

Aspirin Cortisone Other:____

Nose Drops Hormones ____

Laxatives Sedatives

Vitamins Birth Control Pills

Are you allergic to any medications or foods? Yes No If yes please list______________

____

MEDICAL HISTORY: **Please circle if applicable**

Thyroid Disease Diabetes High Blood Pressure Tuberculosis

Kidney Disease Glaucoma Heart Disease Heartburn/Reflux

Depression Liver Disease Other:______________________________________

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Please check if applicable

Does anyone in your home smoke? Yes___ No ___ Do you smoke Yes___ No____

Have you ever smoked Yes No Years smoked_______ When did you stop________

Heating System: Hot water baseboard____ Forced Hot air______ Electric Baseboard______ Gas____
Oil____ Woodburning Stove_________ Fireplace___________

Air Conditioning: Yes___ No___ Central____ Window Unit____ Fans____

Humidifier: Yes____ No__ Central ____ Room Unit___

Dehumidifier: Yes__ No__ Central____ Room Unit___

Animal Exposure: Cat___ Dog___ Bird___ Other______________

Carpets in bedroom: Yes___ No___ Wall to Wall _____ Area Rug____

Carpets in Living Areas Yes____ No_____ Wall to Wall___ Area Rug____

Upholstered Furniture Bedroom_____ Living Areas____________

Type of Mattress: Regular_____ Water_____ Age of Mattress______

Pillow: Feather____ Non-Feather_____ Comforter: Feather____ Non Feather:_____

FAMILY HISTORY

Is there a family history of Allergy?____________________

Which family member:

Mother	Asthma	Hayfever	Eczema	Hives	Sinus
Father	Asthma	Hayfever	Eczema	Hives	Sinus
Brother/Sister	Asthma	Hayfever	Eczema	Hives	Sinus
Children	Asthma	Hayfever	Eczema	Hives	Sinus

Patient or Guardian Signature__________________________________ Date___________________

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PATIENT HIPAA AWARENESS

I have read a copy of the Notice of Privacy Practices.

With my permission, Philip Pasternak, MD may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations.

With my permission, the office of Philip Pasternak MD may contact me by mail, fax or phone at my residence or other designated locations and leave a message on voice mail, answering machine, or in person, in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including pathology and laboratory results, among others.

By signing this, I am allowing Philip Pasternak, MD to use and disclose my protected health information for treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

______________________________ ______________________________
Signature of Patient or Legal Guardian | Print Name of Patient or Legal Guardian

______________________________ ______________________________
Patient's Name | Date

I make the following special request for confidential communications

____

____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign: ______________________________

Communication Barriers: ______________________________

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PATIENT'S INSURANCE POLICIES/ RESPONSIBILITIES

Patient's Name (print please) ______________________________

Your Responsibility: Familiarize yourself with the terms of your insurance coverage. You will be responsible for co-payments, deductibles and other non-covered services that insurance does not pay. A copayment is required at time of visit. Please be prepared to provide a copy of your health insurance card prior to services

Our Commitment: For most insurance plans, we will bill your insurance company on your behalf. You will be responsible for paying any amount of your bill that your insurance company does not pay. If you make an overpayment, we will refund the amount after we receive all payments from your insurance company.

If You Are a Member of an HMO or PPO

Your Responsibility: Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) sometimes have special requirements, such as a Referral from your primary doctor or pre-certification for certain procedures. You are responsible for ensuring that all the requirements of your health insurance plan are met. If the requirements of your plan are not met, you will be responsible for payment of all or part of the services rendered by the doctor.

Our Commitment: If we accept insurance assignment, we will bill your insurance company on your behalf. We will request additional payments from you for any amounts of your bill that your insurance company does not pay. If you make an overpayment, we will refund the amount after settlement with your insurance company.

If You Are Covered by Medicare

Your Responsibility: Familiarize yourself with your Medicare benefits. Medicare may pay all or a portion of your office visit charges, but understand that non-covered fees are your responsibility. Be aware that Medicare specifically excludes payment for certain services. Prior to services, please provide a copy of your Medicare card. Medicare deductible and coinsurance amounts are your responsibility, unless you have a Medicare supplemental policy that covers your Medicare Part B deductible/coinsurance.

Our Commitment: We will Medicare on your behalf. If you have a Medicare supplemental insurance policy or secondary insurance, we will bill them for you as well.

If You Are Covered by Medicaid

Your Responsibility: Familiarize yourself with your Medicaid benefits, and understand that non-covered fees are your responsibility and are due at time of visit. Medicaid may pay for all of your charges except for personal convenience items, depending on the type of coverage, but be aware that Medicaid has payment limitations on a number of services. Prior to services, please provide a copy of your Medicaid card.

Our Commitment: We will bill Medicaid on your behalf.

PATIENT/GUARDIAN SIGNATURE: ______________________

DATE: ______________________