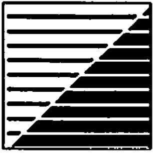


JACKSON ALLERGY & ASTHMA CLINIC

(PLEASE PRINT OR WRITE LEGIBLY)

151 Harmony Park Circle
Hot Springs, AR 71913
501-623-1311

PATIENT INFORMATION

DATE:

PATIENT'S NAME LAST FIRST INITIAL	MARITAL STATUS S M W DIV SEP	DATE OF BIRTH	SOCIAL SECURITY NO.
STREET ADDRESS ☐PERMANENT ☐TEMPORARY	CITY AND STATE	ZIP CODE	HOME PHONE NO.
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE		ZIP CODE
IN CASE OF EMERGENCY CONTACT:			DRIVER'S LIC. NO.
SPOUSE'S NAME			
SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE		ZIP CODE
WHO REFERRED YOU TO THIS PRACTICE?			

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME	STREET ADDRESS, CITY, STATE and ZIP CODE		HOME PHONE NO.
MOTHER'S EMPLOYER	OCCUPATION	SOCIAL SECURITY NO.	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE		ZIP CODE
FATHER'S NAME	STREET ADDRESS, CITY, STATE and ZIP CODE		HOME PHONE NO.
FATHER'S EMPLOYER	OCCUPATION	SOCIAL SECURITY NO.	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE		ZIP CODE

INSURANCE INFORMATION

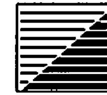
PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE and ZIP CODE		HOME PHONE NO.
☐COMPANY NAME & ADDRESS	NAME OF POLICYHOLDER	CERTIFICATE NO.	GROUP NO.
☐COMPANY NAME & ADDRESS	NAME OF POLICYHOLDER	POLICY NO.	
☐COMPANY NAME & ADDRESS	NAME OF POLICYHOLDER	POLICY NO.	

☐MEDICARE	☐MEDICARE NO.	☐MEDICAID	PROGRAM NO.	COUNTY NO.	ACCOUNT NO.

AUTHORIZATION: I hereby authorize the physician indicated above to furnish information to insurance carriers concerning this illness/accident, and I hereby revocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

____
Responsible Party Signature

Howell - 18958 3/09



JACKSON ALLERGY & ASTHMA CLINIC

Date ______________________

Patient's Name ____ Age __________

Referring Physician ____

1. Chief Complaints: (check your main symptoms, those that prompted your visit here)

HEAD OR NOSE SYMPTOMS		CHEST SYMPTOMS		SKIN SYMPTOMS	
sneezing	____	cough	____	hives	____
nose blocking	____	wheezing	____	eczema	____
runny nose	____	shortness of breath	____	itching	____
postnasal drainage	____	chest infections	____	swellings	____
sinus infections	____	hoarseness or			
sore throat	____	loss of voice	____	INSECT STINGS	
ear blocking	____			hives-swelling	____
headache	____			shortness of breath	____
eye symptoms	____			wheeze	____
				dizziness	____
				passing out	____

OTHER

Please explain in a few words: ____

____

2. Approximately how many years have you suffered from the chief complaints of:

Head or nose symptoms (years) __________ Chest symptoms (years) __________ Skin symptoms (years) __________

Insect sting reactions (years) __________ Other (years) __________

Please note: This information may be important for your insurance coverage, especially in a patient who has recently obtained new insurance.

3. If you have respiratory symptoms indicate their pattern:

	Head/Nose	Chest
Year round, no seasonal variation	________	________
Year round, worse seasonally	________	________
Seasonally only	________	________

If seasonal, list months ____

4. Do you note increased symptoms from any of the following:

a. ALLERGENS				b. IRRITANTS			
Mowed Grass	____	House Dust	____	Perfumes	____	Smoke	____
Dead Grass	____	Cats	____	Soaps	____	Paint	____
Dead Leaves	____	Dogs	____	Detergents	____	Hair Spray	____
Hay	____	Feathers	____			Outside Dust	____

c. WEATHER CHANGES		d. INGESTANTS	
Windy Days	____	Alcoholic Beverages	____
Cold Fronts	____	Drugs	____
Temperature Change	____	Foods	____
Damp Weather	____	Please List Specific Ingestants	______________________

____

(Please Turn Page Over)

Patient's Name ______________________________ **Date**__________________

5. List medicines you use for relief of allergy symptoms ______________________________

____

6. List any other drug you take regularly for any reason - include all over-the-counter drugs, creams, suppositories, eye drops, etc. ______

____

____

7. List any other drug you take occasionally for any reason______________________________

____

8. Are you allergic to any drug? Yes________ No________ . If so, please list drugs: ______________________

____

9. Do you use nose drops or sprays? Yes________ No________ . If so, how often?

   Occasionally________ Regularly__________

   Name(s) of spray(s) or drop(s): ______________________________

10. Have you taken hyposensitization shots ("allergy shots") previously? Yes________ No________ .

11. Are you still taking them? Yes________ No________

    If not approximately how long did you take them?__________________ When did you quit?__________________

12. Is there a history of any of the following in your family?

	Yes	No	Relative: (e.g. Mother, Father, Sibling, etc.)
asthma			______________________
hayfever			______________________
nasal polyps			______________________
eczema			______________________
hives			______________________

13. Do you have any pets at home? Yes________ No________ . If so, what kind? ______________________

    Kept outside completely__________ Outside some, inside some__________ Inside most of time ______________

14. How long has it been since you have had a chest x-ray? ______________________________

15. Have you ever had a sinus x-ray? Yes________ No________ . If so, when ______________________

16. Do you smoke? Yes________ No________ . If so, how many packs per day__________ and for how long? ____________

17. Have you ever smoked? Yes________ No________ Packs per day__________ How long? ______________

18. Can you take aspirin? Yes________ No________

Patient's Name ______________________ Date ____________

5. List medicines you use for relief of allergy symptoms ______________________

____

6. List any other drug you take regularly for any reason - include all over-the-counter drugs, creams, suppositories, eye drops, etc. ______

____

____

7. List any other drug you take occasionally for any reason ______________________

____

8. Are you allergic to any drug? Yes________ No________. If so, please list drugs: ______________________

____

9. Do you use nose drops or sprays? Yes________ No________. If so, how often?

Occasionally________ Regularly________

Name(s) of spray(s) or drop(s): ______________________

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If not approximately how long did you take them?____________ When did you quit?____________

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	Yes	No	Relative: (e.g. Mother, Father, Sibling, etc.)
asthma			____________
hayfever			____________
nasal polyps			____________
eczema			____________
hives			____________

13. Do you have any pets at home? Yes________ No________. If so, what kind? ____________

Kept outside completely________ Outside some, inside some________ Inside most of time ________

14. How long has it been since you have had a chest x-ray? ____________

15. Have you ever had a sinus x-ray? Yes________ No________. If so, when ____________

16. Do you smoke? Yes________ No________. If so, how many packs per day________ and for how long? ________

17. Have you ever smoked? Yes________ No________ Packs per day________ How long? ________

18. Can you take aspirin? Yes________ No________

Page 2 - Patient Information

Patient's Name: ______________________ Date: ______________________

19. List all hospitalizations in order of most recent:

CAUSE OF HOSPITALIZATION: AGE WHEN HOSPITALIZED:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________

DO YOU HAVE THE FOLLOWING	YES	NO
20. Stomach Ulcer (Peptic Ulcer)		
21. Diabetes		
22. High Blood Pressure		
23. Glaucoma		
24. Other Problems with Stomach or Bowels		
25. Other Problems with Heart		
26. Problems with Nervous System		
27. Problems with Urinary Tract		
28. Problems with Blood		
29. Problems with Bones or Joints		
30. History of Hepatitis		
31. History of Blood Transfusion		
32. History of HIV/Aids		

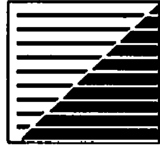
List any Medical Problems you have not noted above: ______________________

33. At your work place are you exposed to allergens or irritants? YES ______ NO ______

If Yes, briefly explain: ______________________

34. Do you have hobbies or past times that expose you to allergens or irritants? YES ______ NO ______

If Yes, briefly explain: ______________________



JACKSON ALLERGY & ASTHMA CLINIC

151 Harmony Park Circle
Hot Springs, AR 71913
501-623-1311

Patient Name: ____________________

Date of Birth: ____________________

Social Security #: ____________________

Telephone #: ____________________

A "Non-kept Appointment" fee will be charged unless your scheduled appointment is cancelled within 24 hours of that appointment time.

There will be a medical records fee charged for any requested records, plus payment of any outstanding patient balance.

Authorization to release or request medical information

I hereby authorize Brian D. Jackson, M.D., to release or request any medical data necessary in the course of my examination or treatment.

Signed: ____________________

Date: ____________________

Howell# 18954 3/09

PATIENT CONTACT & EMERGENCY SHEET

PATIENT NAME: ______________________________

PHONE NUMBER: ______________________________

WORK NUMBER: ______________________________

CELL NUMBER: ______________________________

MESSAGE NUMBER: ______________________________

EMERGENCY CONTACT NUMBER: ______________________________

ALLERGIES: ______________________________

MEDICATIONS: ______________________________

151 Harmony Park Circle
Hot Springs, AR 71913
501-623-1311

FINANCIAL POLICY

The Jackson Allergy & Asthma Clinic thanks you for choosing us as your specialty health care provider. Your understanding of our financial policy is an important part of your care and professional relationship. Please ask if you have any questions regarding our fees, Financial policy, or your responsibility.

Full payment for office visit charges is due at the time of service if you do not have insurance coverage. We accept cash, check, money order or credit card (Visa, Mastercard and Discover). Should you need to make payment arrangements, please contact our Patient Representative before your scheduled appointment time. We will make every effort to reach mutual agreeable terms.

We are happy to answer any question you may have about the charges for your allergy care, including allergy injections.

INSURANCE
Jackson Allergy & Asthma Clinic files claims with all commercial insurance companies. Any copays, deductibles, co-insurance payments, or non-covered services are your responsibility and are due at the time of service.

IF YOUR INSURANCE REQUIRES A REFERRAL, YOU ARE RESPONSIBLE FOR MAKING SURE A REFERRAL IS OBTAINED BY THE DATE OF SERVICE. If our office does not have a referral at the time of service and your insurance does not pay, you will be responsible for the charges for services rendered.

Statements are sent out at least once a month. All patient balances billed are due within 14 days of receipt of the statement. You are directly responsible for any unpaid balance on you account. If payment cannot be made when due, you must contact our Patient Representative to set up an extended payment arrangement.

After 60 days, if no payments have been made and no extended payment arrangements have been set up, necessary collection efforts will begin.

In divorce cases, regardless of who has been awarded custody or financial responsibility for the child, the person bringing the child for treatment is responsible for payment of services rendered.

Jackson Allergy & Asthma Clinic is committed to providing you and your family with the best medical care possible. Our charges reflect the usual and customary fees for our area. You are responsible for payment regardless of any insurance companies' arbitrary determination of benefits.

FINANCIAL POLICY:

I have read the Financial Policy of Jackson Allergy & Asthma Clinic. I understand that I am financially responsible for all charges whether or not covered by insurance.

X __________________________________ Date: ________________
Patient Signature (If under 18 yrs, Signature of Parent/Guardian)

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ______________________, understand that as part of my health care, Jackson Allergy & Asthma Clinic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Jackson Allergy & Asthma Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Jackson Allergy & Asthma Clinic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Jackson Allergy & Asthma Clinic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

____
Patient's Signature

____
Date

FOR OFFICE USE ONLY

[ ] Consent received by ____________________________ on ___________________.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on ________________________.

I fully understand and accept / decline the terms of this consent.

____
Patient's Signature

____
Date

FOR OFFICE USE ONLY

[ ] Consent received by ___________________________ on __________________.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _______________________.