LABS ___ IMAGING___ NONE___

GWINNETT CLINIC – ALLERGY & ASTHMA SPECIALIST
DR. BYOL SHIN

Patient Name: _____ DOB: ____/____/____ Date: ____/____/____
Regular Family or Medical Doctor (Name): _____
Referring Doctor Name:_____
Reason for today's visit: _____
Patient's Age: _____

NEW PATIENT FORM

SYMPTOMS:
(Chief Complaint)

Have you had any of the following symptoms?

1. ( ) Sneezing
2. ( ) Runny Nose
3. ( ) Blocked Nose
4. ( ) Itchy Eyes
5. ( ) Watery Eyes
6. ( ) Post Nasal Drip
7. ( ) Itchy Nose
8. ( ) Sinus Pressure/Pain
9. ( ) Coughing
10. ( ) Wheezing
11. ( ) Shortness of Breath
12. ( ) Chest Tightness
13. ( ) Headache
14. ( ) Eyelid Swelling
15. ( ) Lip Swelling
16. ( ) Hives
17. ( ) Rash
18. ( ) Nausea/Diarrhea
19. ( ) Acid Reflux
20. ( ) Eczema

HISTORY OF PRESENT ILLNESS:

ALLERGIC RHINITIS

1. When do you get symptoms? __ Spring __ Summer __ Fall __ Winter __ All Year

COUGHING AND ASTHMA

1. Have you ever been diagnosed with asthma? __ Yes __ No
2. Do you have shortness of breath, cough or wheezing? __ Yes __ No

SINUSITIS

1. Do you have sinus pain or pressure? __ Yes __ No
2. Any discolored (yellow or green) discharge from nose? __ Yes __ No

NON – ALLERGIC RHINITIS

1. Do you get more nasal congestion when you are around perfume? ___or smoke?___

HIVES

Do you have hives? ____ Are they red, raised, and itchy? _____
Does each individual hive go away within 24 hours? _____
Do the hives leave a bruise when they resolve? _____
Do you take Aspirin? _____
Are they associated with any foods or meds? _____ Which ones? _____
Did you have any infections (including colds) before or during your hives? _____

Dr. Signature _____ Date ____/____/____

Patient Name: _____DOB: _____/____/____ Date:____/____/_____

PAST MEDICAL HISTORY:

Have you ever had:

( ) Migraine Headache
( ) Sinus/nose septum surgery
( ) Bronchitis
( ) Asthma
( ) Hives
( ) Eczema
( ) Food Allergies
( ) Drug Allergies
( ) Sensitivities to insect stings
( ) Nasal polyps
( ) Hypertension
( ) Diabetes
( ) Other:

_____
_____
_____

HOME ENVIRONMENT:

Does your house have:

( ) Central air conditioning
( ) Heating units
( ) Forced air
( ) A damp basement
( ) Visible mold or moldy smell
( ) Carpeting
( ) Family members who smoke
( ) Dust Mite covers on pillows, mattresses, and boxsprings

Do you Have a:

( ) Cat
( ) Dog
( ) Bird
( ) Other Animal _____

SOCIAL HISTORY:

Do you have any history of alcohol abuse? Y or N

Do you have any history of substance abuse? Y or N

How many packs of cigarettes do you smoke per day? _____

For how many years? _____

Are you pregnant or are you planning to be? _____

Occupational: _____

FAMILY HISTORY:

Do any of these family members have allergies or asthma?

( ) Mother
( ) Father
( ) Sister (s)
( ) Brother (s)
( ) Other Relatives:

`

KNOWN DRUG ALLERGIES:

_____
_____
_____
_____
_____
_____

KNOWN FOOD ALLERGIES:

_____
_____
_____
_____
_____
_____

INSECT STING ALLERGIES:

_____
_____
_____
_____
_____
_____

MEDICATIONS:

Please List:

_____
_____
_____
_____
_____
_____
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_____
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_____

_____
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_____

Dr. Signature _____ Date ____/____/____

Patient Name: _____DOB: _____/____/____ Date:____/____/_____

REVIEW OF SYSTEMS:

	(+)		**(–)**
Constitutional:	_____		_____
Eyes:	_____		_____
ENT:		see above	
Cardiovascular:	_____		_____
Respiratory:	_____		_____
Digestive:	_____		_____
Urologic:	_____		_____
Gynecologic:	_____		_____
Skin:	_____		_____
Neurologic:	_____		_____
Psychiatric:	_____		_____
Endocrine:	_____		_____
Musculoskeletal	_____		_____
Allergic		see above	

ADDITIONAL COMMENTS:

Dr. Signature _____ Date ____/____/____

Patient Name: _____DOB: _____/____/____ Date:____/____/_____

BP _____ P _____ R _____ H _____ WT _____ T _____ O2 _____%

___ General (Head, Affect/Orientation)
___ Eyes (Conjunctiva, Lids)
___ Ears (Canals, TM's)
___ Nose (Mucus, Septum/Turb, Pus, Polyps)
___ Sinuses (Tender, Shiners)
___ Oropharynx (Teeth/Gums, Mucosa, Palates, Tonsil)
___ Neck (Masses, Symmetry, Trach, Nodes, JVD, Thyroid)
___ Chest (Symmetry/Expiratory effort, Rhythm, Gallops, Rubs)
___ Heart (Pulses, Murmurs, Rate, Rhythm, Gallops, Rubs)
___ Abd (Bowel sounds, Palpitation, Tender)
___ Ext's (Clubbing, Cyanosis, Edema)
___ Skin/Lymph ____=**NORMAL**

Skin Testing: _____

FENO:
_____PPB

	Pre	Post
FVC	_____	_____
FEV1	_____	_____
%	_____	

Data Review: Skin tests, CT Sinuses, PFT's, Records, Correspondences, Chest X-ray, Immunology Record

Impression:

Plan:

Discussion:
Pets
Dust Mites
Smoke
Mold
Pollen
Diet
IT Risks and Benefits

Handouts:
Rhinitis
Asthma
Dust Mites
Pets
Mold
Urticaria
Angioedema
Anaphylaxis
Food
Venom
IT
Eczema
Aspirin
Pregnancy

____ Demonstrated utilization of nebulizer, meter dose inhaler device.
____ Albuterol/DuoNeb inhaltion treatment provided.

RTC_____WKS/MTHS

Dr. Signature _____ Date _____/_____/_____

Inj/Vacc. Name _____Lot _____ Exp _____

Inj/Vacc. Name _____Lot_____ Exp _____

GWINNETT CLINIC

Date of visit: _____/_____/_____

PATIENT NAME: _____ _____ _____
LAST NAME FIRST NAME MI

STREET ADDRESS: _____ APT # _____

CITY: _____ STATE_____ ZIP CODE: _____

TELEPHONE #: _____ _____ _____
HOME WORK CELL

Date of Birth: _____/_____/_____

Social Security Number: _____ - _____ - _____

Insurance Company: _____

_____ _____
Patient Signature Date

Allergy and Asthma Clinic

Pharmacy Information

Name: _____ Date of Birth:_____

Do you use Gwinnett Clinic Pharmacy at Lawrenceville, please check here:

Yes____ No____

If no, please provide your pharmacy information for future e-prescriptions.

Pharmacy Name:_____

Phone#:_____

Address:_____
(Please include the city/road name if you are not sure of the exact address)

GWINNETT CLINIC

Referral Information Form

How did you hear about us? (Please check all that apply)

- Referred by Physician Name:_____

  Practice Name: _____

  Phone#: _____ Fax#: _____

  Address: _____

  _____

- Internet Search: _____
- Friend/ Family Member:_____
- Insurance Company:_____
- Newspaper:_____
- Other:_____

GWINNETT CLINIC

HIPAA/PROTECTED HEALTH INFORMATION

10 Acknowledgement of Receipt of Notice of Privacy Practices

I have been given a copy of ***Gwinnett Clinic's*** Notice of Privacy Practices, version effective September 2013.
I consent to the uses and disclosures of my health information as outlined in the Notice.
I understand that I can access the Notice of Privacy Practices at any time on the Gwinnett Clinic website.

PRINT NAME OF PATIENT _____ DATE _____

SIGNATURE OF PATIENT OR REPRESENTATIVE _____ PRINT NAME OF REPRESENTATIVE (IF APPLICABLE) _____

If Representative signing on behalf of patient, please describe the Representative's authority to act on behalf of the patient (**initial one**):

_____ The representative is the parent of the patient, who is a minor.

_____ The representative is the guardian of the patient, who has been adjudicated incompetent.

_____ The representative is acting under a Durable Power of Attorney for Health Care for the patient, and has presented a copy of this document to Gwinnett Clinic personnel.

11 Communicating About Your Care

Necessary medical care at Gwinnett Clinic:
- I understand these communication methods are essential to receiving the best quality care.
- I understand Gwinnett Clinic will respect and maintain my privacy to the best of its ability.
- Automated phone, automated text, personalized text, and patient portal utilization are necessary for my care.

What number do you prefer we use to contact you? _____

Do we have your permission to:

Leave a message on your answering machine?	☐Yes	☐No
Confirm appoinments?	☐Yes	☐No
Remind you of any medications (if applicable)?	☐Yes	☐No

If we cannot reach you, who can we speak to about your care?

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

GWINNETT CLINIC

FINANCIAL POLICY

WE HOPE TO MAKE YOUR VISIT IN OUR OFFICE AS THOROUGH AND PLEASANT AS POSSIBLE. WE ALSO WANT YOU TO HAVE A FULL UNDERSTANDING OF YOUR INSURANCE PLAN AS WELL AS OUR FINANCIAL POLICIES AND EXPECTATIONS FOR PAYMENT. PLEASE READ THIS DOCUMENT CLOSELY.

INSURED PATIENTS

Payment is due at the time services are rendered. This includes outstanding balances, deductibles, co-payments, co-insurances, other fees for services not covered by your insurance company, and expected charges for services rendered during your visit.

- Your payment at check-in is a deposit for the visit. Charges may also be collected at check-out for services rendered. This applies to all insurance plan types. You will subsequently receive an explanation of benefits from your insurance company, and, if needed, statements from your insurance company and Gwinnett Clinic to collect any outstanding balance.
- If you are not sure what your insurance covers, PLEASE CALL YOUR INSURANCE COMPANY DIRECTLY! As the insured member, you are in the best position to get accurate information. As there are hundreds of insurance plans, we are only to provide general cost estimates. In addition, the information given to us comes with a disclaimer that it may be inaccurate.
- As a courtesy, we assist with filing insurance claims, completing insurance forms, and requesting insurance pre-certifications.
- In short, the ULTIMATE RESPONSIBILITY for filing, processing, and paying claims remains with you. If your insurance has not paid their portion within ninety (90) days of being billed, we encourage you to continue contacting them. (Please note that insurance carriers may provide false or inaccurate information at time of initial benefits verification.)
- You will receive regular statements requesting payment of any unpaid balance. After two (2) statements, your balance will be forwarded to a third-party collection agency.

PRIVATE PAY (NO INSURANCE)

Gwinnett Clinic will collect full payment at the time of your visit for services rendered during the visit.

- Prior to your visit (at check-in), an office visit fee – along with payment for all previously unpaid balances – is collected.
- After seeing the physician / nurse practitioner (at check-out), there may be additional charges depending on the level of service that was provided by the physician or nurse practitioner and the additional services (labs, imaging, etc.) that may have been ordered / rendered during the visit.
- If additional tests are ordered that need to be completed after the visit, and you anticipate a problem paying for these – please let your health care team know before leaving the office.

ALL PATIENTS

Gwinnett Clinic will collect full payment at the time of your visit for services rendered during the visit.

- *NO-SHOWS: $25 (office visits not cancelled within 24 hours prior to appointment may result in a $25 charge; there may be significantly higher charges for missing scheduled tests, including stress tests and sleep studies)
- BOUNCED CHECKS: $35.00 (any checks returned by the bank)
- FORM FEES: $15 - $150 (applicable to each form completed your physician / NP beyond standard medical documentation)

*No show fees may be adjusted or waived at the discretion of the Medical Director.

Adoption Forms *minimum $150, must be completed by physician only*	**Handicap Parking Forms/ Parking Permits** *minimum $15*	**School Admission Forms** *minimum $15*
Employment Screening Forms *minimum $15*	**Health Screening/Biometric Exam/ Proof of Wellness Visit Forms** *no charge if 1 page only, otherwise minimum $15*	**Sports Physical** *minimum $20*
FMLA Forms *minimum $50*	**Immunization Forms** *minimum $15*	**Short Term Disability Forms** *case-by-case basis, minimum $20*

12 Financial Policy Acknowledgement

I have read in full and understand the above policies. I know that I will be charged a minimum of $15 for any form beyond standard clinical documentation. I understand that I may receive a copy of this form upon request. I understand that if I pay with debit/credit card, Gwinnett Clinic securely saves that information in my patient profile and may use it to charge unpaid balances on my account after 90 days.

PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE _____ SIGNATURE _____

DATE _____ RELATIONSHIP TO THE PATIENT (IF APPLICABLE) _____

GWINNETT CLINIC

PATIENT PORTAL, PHONE & DIGITAL COMMUNICATION CONSENT FORM

WE USE YOUR CELL PHONE NUMBER AND E-MAIL ADDRESS PRIMARILY FOR APPOINTMENT CONFIRMATIONS AND FEEDBACK. WE DO OUR UTMOST TO RESPECT AND MAINTAIN PRIVACY. WE WILL NEVER SEND SPAM E-MAIL / TEXTS OR SHARE YOUR CONTACT INFORMATION.

It is important to make you aware of the intent of electronic correspondence and potential risks involved with it. This consent concerns currently available and future communication methods between you and Gwinnett Clinic. Of note, digital communication includes, but is not limited to, email, patient portal, text messages/SMS, etc. Gwinnett Clinic only uses secure and encrypted software to communicate with you. However, Gwinnett Clinic is not responsible for a breach of information if your device is not secure.

CONDITIONS FOR THE USE OF PATIENT PORTAL, PHONE & DIGITAL COMMUNICATION

Gwinnett Clinic cannot guarantee, but will reasonably strive, to maintain security and confidentiality. Please note:

- *Patient portal, phone or other digital communication is not appropriate for urgent or emergency situations.*
- You should never use email or other digital communication to discuss sensitive medical information.
- It is your responsibility to follow-up and/or schedule an appointment if warranted.
- If you opt in to participate in email and other digital communicaton with Gwinnett Clinic, it is understood that you are responsible for the security and privacy of the recipient email client, cell phone, tablet, etc.
- If you opt in to participate in email and other digital communication with Gwinnett Clinic, it is understood that most widely available software (e.g. email service providers, email clients, text message/SMS services, wireless communication providers, etc.) and hardware (e.g. cell phones and computers) are neither HIPAA-certified nor encrypted.
- In short, it is your responsibility to maintain the security of all email and digital communication.

RISK OF USING PATIENT PORTAL, PHONE & DIGITAL COMMUNICATION

Transmitting information by email & other digital means has a number of risks, including, but are not limited to:

- Email and other digital communication can be circulated, forwarded, stored, and broadcast.
- Email and other digital communication can mistakenly use the wrong email address, phone number, etc.
- Backup copies of email/other digital communication may exist even after deleted.
- Employers and online services may have a right to inspect email and all other digital communication.
- Email and other digital communication can be intercepted, changed, forwarded, etc. without authorization.
- Email and other digital communication can be used to introduce viruses into hardware.
- Email and all other digital communication can be used as evidence in court.
- Gwinnett Clinic's server and/or information technology infrastructure could go down and neither email nor any other digital communication would not be received until the server is back online.
- **I consent to receiving automated appointment reminders and other essential communication regarding my appointments and medical care by automated phone calls and text messages. I understand that Gwinnett Clinic will never sell my information to a third party.**

13 Communicating with Gwinnett Clinic Staff and Approved Contractors

Gwinnett Clinic may engage in staffing arrangements with contract workers both in and outside the United States. All are trained on US compliance standards and HIPAA privacy and security. Contract staff may be used for care provided in the office or for support services when you are communicating with the clinic before or after visits.

14 Permissions

_____ (initials) **YES**, I consent to Gwinnett Clinic's standard communication protocols. I understand that patient portal, phone, and digital communication are not appropriate for emergency situations.

EMAIL ADDRESS **(REQUIRED)** _____ CELL PHONE # _____

15 Patient Portal, Phone & Digital Communication Acknowledgement

I have read in full and understand the intent of electronic correspondence and potential risks involved with it. I understand that I may receive a copy of this form upon request.

PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE _____ SIGNATURE _____

DATE _____ RELATIONSHIP TO THE PATIENT (IF APPLICABLE) _____