Patient Intake Form

Manav Segal, M.D.

Chestnut Hill Allergy & Asthma Associates, LLC

Patient Name:_____ **Today's Date:**_____

Last First Middle

How would you like to be addressed by the doctor:_____

Address:_____

E-mail address:_____

Home Phone: _____ **Cell Phone:**_____

How would you like to be contacted for reminder calls: ___voice call ___text message

Occupation:_____

Date of Birth: _____**Gender:** M or F **Height:**_____ **Weight:**_____

Parent /Guardian Name(if under 18 yrs of age)_____**relation:**_____

Primary Care Physician:_____(first & last name)

Phone:_____

Pharmacy:_____ **Phone:**_____

Race: (please check all that apply) __American Indian /Alaska Native __Asian

__Native Hawaiian or Other Pacific Islander __Black or African American __White __Hispanic Latino

__Other Race __Unreported/Refused to Report

Ethnicity: __Hispanic/Latino __Non Hispanic/Non Latino

Primary Language:_____

Reason for Visit (please check all that apply):_____

__Hives/Urticaria __Asthma/Wheezing __Other(Please describe)

__Allergy Symptoms __Food/Drug Allergy _____

Current Medications:_____

_____

_____

Patient Intake Form

Drug Allergies (please check all that apply):

____Sulfa ___Contrast Dye _____NKDA (no known drug allergies)
____Penicillin ___Latex _____Other(Please describe)_____

Medical History

__asthma __hypertension __diabetes ____Reflux/GERD

__other(please describe)_____

Smoking History : **Pets** ___Yes __No

____ Non-smoker #___cats #___dogs ___other

____Smoker ____age started ____age quit

____1/2ppd ____1ppd ___2ppd

Surgical History:_____

_____

_____

Please furnish your insurance and prescription cards to be photocopied

Primary Insurance:_____

ID#:_____Group#:_____

Guarantor:_____DOB:_____Relationship:_____

Secondary Insurance:_____

ID#:_____Group#:_____

Guarantor:_____DOB:_____Relationship:_____

Failure to provide this information could result in you being billed

I authorize Manav N. Segal, M.D. to release any medical information acquired in the course of my treatment that is necessary for payment and health care operations. This office has a Notice of Privacy Practices which describes how we may use and disclose your protected health information. We reserve the right to make revisions as necessary whenever required. You can access this information at any time, including any revisions, and exercise other rights concerning protected information. I assign directly to Dr. Segal all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by the insurance along with any collection costs that might be incurred. I authorize the use of my signature on all insurance submissions.

Authorized signature:_____ **Date**:_____