Chestnut Hill Allergy & Asthma Associates, LLC

Patient Intake Form

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

Date of Birth: _____ Gender: M or F or Transgender

Occupation:_____

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

Emergency Contact Name: _____Phone:_____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: Check all that apply:

_____Hives/Urticaria _____Asthma/Wheezing _____Allergy Symptoms

_____Food Allergy _____Drug Allergy _____Other(Please describe)_____

Current Medications: _____

_____

_____

Height: _____ft _____in Weight:_____

Medical Staff Use:

BP_____ P_____ RR_____

Medical History: ____Asthma _____Reflux/GERD _____High Blood Pressure _____Heart Disease ____Diabetes
____ Cancer (type)_____ Other medical problems (please describe):_____

Drug Allergies : Check all that apply.
_____NONE (NKDA=No Known Drug Allergies)
_____PENICILLIN (Reaction: hives stomach upset other:_____)
_____SULFA (Reaction: hives stomach upset other:_____)
_____Contrast Dye _____LATEX
_____Other Drug Allergies: _____

Surgical History: (include year)_____
_____

Family History:
FATHER Age:_____ (alive, deceased, unknown)
History of: ____Diabetes ____ Hypertension ___Heart Disease ___Stroke ____No Known Medical Problems
____Cancer (type)_____ ___Other_____

MOTHER Age:_____ (alive, deceased, unknown)
History of: ____Diabetes ____Hypertension ___Heart Disease ___Stroke ____No Known Medical Problems
____Cancer (type)_____ ___Other_____

Smoking History: ____Former Smoker _____Current Smoker _____NON Smoker

Tobacco Use: ____age started _____age quit ____1/2pk/day ___1pk/day ___2pk/day
Exposure: Does anyone smoke in your house? ____No ____Yes, indicate relation:_____

Household Pets: ____No ____Yes , indicate: #cats_____ #dogs_____ #other_____

Preventative Medicine: Do you get a influenza/flu vaccine yearly? No Yes, indicate date:_____
If 65 & older, Have you ever had a pneumonia vaccine? No Yes, indicate date:_____

Please furnish your insurance and prescription cards to be photocopied

Primary Insurance:_____ ID#:_____

Guarantor:_____ DOB:_____ Relationship:_____

Secondary Insurance:_____ ID#:_____

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:_____