Dr. Mary Anderson
Board Certified Pediatric Allergist

PATIENT INTAKE FORM

Date _____

Patient's Name_____ DOB _____

Primary Physician _____ Referring Physician_____

SYMPTOMS

Please circle/check any chronic symptoms you /your child may have:

Head/Neck Symptoms
Runny/stuffy nose
Bouts of sneezing
Itchy nose/throat/ear canals.
Post nasal drainage
Frequent nosebleeds
Itchy/watery eyes
Snoring
Headaches

Chest/Lung/.Breathing Symptoms
Shortness of breath
Chest tightness
Rattling in chest
Frequent cough
Wheezing
History of Asthma? Yes No

Gastrointestinal Symptoms
Frequent vomiting or diarrhea
Abdominal pain
Heartburn or ulcers
Poor Appetite

Skin Symptoms
Eczema
Hives
Skin itching
Other rash - where_____

SYMPTOM TRIGGERS

Please circle any you think makes your/your child's symptoms worse:

House dust Feathers Animal danders
Molds Damp areas
Tree pollen Grass cutting
Perfumes
Smoke
Exercise
Changes in temperature/humidity/cold air
Latex Sensitivity

ENVIRONMENTAL HISTORY

Please circle or complete answers as appropriate:

Your home is a: House Apartment Mobile Home
Location City Farm Suburbs
How long have you lived there _____ How old is the home_____
Type of mattress Foam Innerspring Other _____
Floors Carpet Wood Linoleum Other_____
House is generally Dry Dusty Moist
Air Conditioning Central Window Units
Heating System Electric Gas Fuel Oil Wood
Change air filters every ____months
Any Pets? Please list number, type and whether indoor or outdoor
_____

Smokers in home Yes No How many_____
How many people in household _____

BIRTH HISTORY

Birth Weight _____lbs _____oz

Breast Fed _____ Bottle Fed? _____

Were there frequent formula changes or special formula needed?_____

ALLERGIES

Describe the reactions, the times they occurred and the actions which seemed to trigger the reactions

_____

_____

Drugs_____

Insects_____

MEDICAL HISTORY

Are immunizations current Yes No Any adverse reactions? Yes No
Any surgery for Ears Nose Sinus Adenoids Tonsils

Ever seen an allergist or ENT physician? _____ If so, when_____
Any serious illness/hospitalizations? _____
Briefly describe any other significant health problems _____
Ever been on allergy shots? Yes No When_____
Most recent sinus or chest X-ray _____

FAMILY HISTORY

Describe allergy symptoms in your family members (asthma, hay fever, sinus, etc)
Father _____
Mother _____

Brother/Sisters_____

Are there any problems you wish to discuss during today's visit?

_____
_____
_____

Please list all medications currently taking

_____ _____

_____ _____

_____ _____

NOTICE OF PRIVACY PRACTICES

This notice describes how protected health information may be used and disclosed and how you may have access to this information. Please review it carefully.

We are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they related to your protected health information.

Understanding your Health Record Information

Each time you visit Pediatric Partners of Augusta, a record of your visit is made. Typically, this record contains your symptoms, examinations and test results, diagnoses, treatment and a plan for future care or treatment. This information serves as a:

-Basis for planning your care and treatment
-Means of communicating among the many health professionals who may contribute to your care
-Legal document outlining the care you received
-Means by which you or a third party may verify that the services billed were actually provided
-Tool to educate other health professionals
-Source of information for Public Health officials charged with monitoring and improving the health of this state and the nation
-Source of data from which PPA can plan for the future care delivery strategies
-Tool by which we can assess and continually strive to improve the care we provide to our patients and the resulting outcomes

Having a better understanding of what your health information is and how it is used will help you to: ensure its accuracy, make more informed decisions when authorizing disclosure to others, and better understand both who and why others may access your health information.

Your Rights:

Although your health record is the property of Pediatric Partners of Augusta, LLC, the information contained herein belongs to you. You have the right to:

-Request a paper or electronic copy of this notice of Privacy Practices upon request.
-Inspect and copy your health record.
-Request that your health record be amended.
-Obtain an accounting of disclosures of your health information. To accomplish this, please contact the Administrator.
-Request that restrictions be places upon the use or disclosure of your health information
-Revoke your authorizations to use or disclose your health information.
-Request that we not submit your health information to your health insurance carrier if you have paid for the service in full yourself.
-Request an electronic copy of your health record.
-Restrict specific disclosures to your health insurance carrier if you have paid for the service in full yourself.

Our Responsibilities

Pediatric Partners of Augusta, LLC is required to:

-Maintain the privacy of your health information
-Provide you with this notice of our Privacy Practices
-Abide by the terms and condition so f this Agreement
-Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
-Notify you of a breach of unsecured health information

We will not use or disclose your health information without your authorization, except as described in this notice. To revoke your authorization, please contact the Administrator in writing. If you have questions and would like additional information, please contact the Administrator at 706.854.2517.

If you believe your privacy rights have been violated, you can either file a complaint with the Administrator or with the Office of Civil Rights, US Department of Health and Human Services. There will no retaliation against you or your children for filing a complaint to either party.

The address for the OCR is:

Office for Civil Rights
Us Department of Health and Human Services
200 Independence Avenue, SW
Room 509 HHH Building
Washington, DC 20201

Examples of Disclosures for Treatment, Payment and Healthcare Operations

We will use your health information for treatment

For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your electronic health record and used to determine the course of treatment that the provider would work best for you. Your physician will document in your health his or her expectations of the other members of your health care team who will participate in your care. These members will then record the actions they took and their observations. By examining these, your physician will assess how you are responding to treatment.

We will share your medical information as permitted under federal law (HIPAA) and Georgia state law, with healthcare providers through a statewide Health Information Exchange.

We will use your health information for payment

For example: A bill for services rendered may be sent to you or a third party payor. The information accompanying this bill may include information that will identify you,, your diagnosis procedures and supplies used.

We will use your health information for regular health operations

For example: Our providers, clinical staff or other members of the quality improvement team may use information in your health record to assess the care rendered, and the outcomes achieved in both your and similar cases. This information will then be used in a continuous effort to improve the quality and effectiveness of the healthcare and services we provide.

Notification: We may use or disclose information to notify or assist in notifying a family member, other relative, or any other person responsible for your care that you so identify your care and your general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, or any other person that you so identify health information relevant to that person's involvement in your care of payment related to your care.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Reminders: We may contact you to provide appointment reminders or information about treatment alternatives of other health related services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and/or product defects, or post marketing surveillance information to enable product recalls, repairs or replacement

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing disease, injury or disability.

Law Enforcement: We may disclose health information as required by law for law enforcement purposes or in response to a valid subpoena

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member of business associate believes in good faith that weave engaged in unlawful conduct or have otherwise violated professional or clinical standards that are potentially endangering one or more patients, workers or the general public.

_____ _____

Signature of Responsible Party Date

The primary caregiver who holds the primary insurance is responsible for the payment of all charges not paid for by the policyholder's insurance (for example: co –pay amounts, deductibles, any services not covered by the insurance company. It is the responsibility of the caregiver bringing the child(ren) to pay all applicable co-payments.

In the event of divorce or separation, it is the mutual responsibility of both caregivers to work together to ensure that all charges not paid by the appropriate insurance company are paid in a timely manner. Pediatric Partners will NOT become involved in how these charges and payments are allocated, if applicable, among parents/guardians.

Patient _____

DOB _____ Social Security # _____ Sex M F

Address _____

Primary Caregiver(s)/Who does child(ren) live with**?** _____

Parent #1 _____ Social Security # _____Marital Status S M D

Relationship to patient _____

Address _____

Preferred Phone # _____ Work Phone #_____

Can confidential messages be left on your voice mail? Yes No E-mail address_____

Parent #2 _____ Social Security # _____Marital Status S M D

Relationship to patient _____

Address _____

Preferred Phone # _____ Work Phone #_____

Can confidential messages be left on your voice mail? Yes No E-mail address_____

Race American Indian | Asian | Black/African American | White | Native Hawaiian | More than One Race

Preferred Language English | Spanish | Other

Ethnicity Hispanic/Latino | Not Spanish/Latino

Primary Insurance Company _____

Name of Policy Holder _____ Relationship to Patient _____

Policy Holder's DOB _____ Social Security #_____

Secondary Insurance Company _____

Name of Policy Holder _____ Relationship to Patient _____

Policy Holder's DOB _____ Social Security #_____

_____ _____

Responsible Party Date

Patient Name _____ **DOB**_____