# ALLERGY PROFILE

## Symptoms of Common Allergies

**Patient Name:**_____ **Date:** _____

**PLEASE PLACE A ✓ BESIDE THE PROBLEMS YOU ARE EXPERIENCING**

| | | | |
|---|---|---|---|
| ☐ SNEEZING | ☐ WATERY EYES | ☐ THROAT DRAINAGE | ☐ THROAT TICKLE |
| ☐ RUNNY NOSE | ☐ SWOLLEN LIDS | ☐ BLOCKED EARS | ☐ WHEEZING |
| ☐ BLOCKED NOSE | ☐ ITCHY EYES | ☐ ITCHY EARS | ☐ TIGHTNESS IN CHEST |
| ☐ LOSS OF SMELL | ☐ SORE THROAT | ☐ EAR INFECTION | ☐ SHORTNESS OF BREATH |
| ☐ HEADACHE | ☐ ITCHY MOUTH | ☐ COUGH | |

Caused by: _____

| | | | |
|---|---|---|---|
| ☐ SKIN ITCH | ☐ SWELLING OF LIPS | ☐ NAUSEA | ☐ IRRITABILITY |
| ☐ RASH | ☐ ITCHY HANDS OR FEET | ☐ DIARRHEA | |
| ☐ HIVES OF WELTS | ☐ STOMACH PAINS | ☐ FATIGUE | |

1. **When did symptoms start?** _____
2. **What is the worst time of the year?** ☐ Spring ☐ Summer ☐ Fall ☐ Winter
3. **What is the best time of the year?** ☐ Spring ☐ Summer ☐ Fall ☐ Winter
4. **What triggers your symptom?** ☐ Weather ☐ Exertion ☐ Infection

**Present Medications:**_____

**Previous treatment:** ☐ **Allergy Testing** ☐ **Allergy Shots** ☐ **Other Medications**

**Are you allergic to any of the following:**

| | | |
|---|---|---|
| ☐ **Animals** | ☐ **Foods** | ☐ **Insects** |
| ☐ **Dust** | ☐ **Medicines** | ☐ **Smoke** |

**What medications are you allergic to?** _____

**Family History:**

Does anyone in your family have allergies? ☐ YES ☐ NO ☐ Unknown (If yes, check below)

☐ FATHER ☐ MOTHER ☐ BROTHER ☐ SISTER ☐ CHILDREN

Is anyone in your family a patient here? ☐ YES ☐ NO

Home Environment:

Your house is ☐ OLD ☐ NEW

Does your home have:

☐ CARPET ☐ AIR CONDITIONING ☐ PLANTS ☐ PETS ☐ SMOKER IN HOUSE

Additional Comments?

**Pramila K. Daftary, M.D.**
221 Jewell Drive
Waco, Texas 76712
254.753.3646

Date: _____
Patient No: _____

## PATIENT INFORMATION

| Patient's Name | Marital Status | Date of Birth | Sex | Social Security No. | Driver's License # |
|---|---|---|---|---|---|
| | | | | | |

| Street Address | City & State | Zip Code | Home Phone | Cell Phone |
|---|---|---|---|---|
| | | | | |

| Spouse's Name | Date of Birth | Social Security No. |
|---|---|---|
| | | |

| In Case of Emergency Contact | Relationship to Patient | Phone No. |
|---|---|---|
| | | |

| Primary Care Physician | Address | Phone No. |
|---|---|---|
| | | |

## EMPLOYER INFORMATION

| Patient's Employer | Occupation | Business Phone No. |
|---|---|---|
| | | |

| Address | City & State | Zip Code |
|---|---|---|
| | | |

| Spouse's Employer | Occupation | Business Phone No. |
|---|---|---|
| | | |

| Address | City & State | Zip Code |
|---|---|---|
| | | |

## IF THE PATIENT IS A MINOR OR STUDENT

| Mother's Name | Address, City, State, & Zip Code | Home Phone No. | Cell Phone # |
|---|---|---|---|
| | | | |

| Mother's Employer | Social Security No. | Driver's License # | DOB | Business Phone |
|---|---|---|---|---|
| | | | | |

| Father's Name | Address, City, State, & Zip Code | Home Phone No. | Cell Phone # |
|---|---|---|---|
| | | | |

| Father's Employer | Social Security No. | Driver's License # | DOB | Business Phone |
|---|---|---|---|---|
| | | | | |

## INSURANCE INFORMATION

| Company | Insured Person |
|---|---|
| | |

## OTHER INSURANCE (IF APPLICABLE)

| Company | Insured Person |
|---|---|
| | |

## RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

| Name | Social Security No. | Driver's License No. | Phone No. |
|---|---|---|---|
| | | | |

| Address | City, State, & Zip Code | Relationship to the Patient |
|---|---|---|
| | | |

| Employer | Phone No. |
|---|---|
| | |

# Assignment of Benefits Form

## Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office.
Necessary forms will be completed to file for instance carrier payments.

## Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Private insurance and any other health/medical plan, to issue payment check(s) directly to Allergy & Asthma Care of Waco for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

I have requested medical services from Allergy & Asthma Care of Waco on behalf of myself, and/or my dependents, and understand that making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid at the original.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date

# Welcome!

We are very pleased you have chosen Dr. Pramila K. Daftary and the staff of Allergy & Asthma Care of Waco to provide gentle solutions for your allergy and asthma needs. We specialize in complete diagnosis, relief, and prevention for adults and children. We are dedicated to establishing a pleasant and professional environment for each of our patients.

## The following is a list of very important items to be completed prior to your visit.

1. Notify our office of your insurance coverage.
2. Be certain your Primary Care doctor has obtained a referral.
3. Stop taking all over-the-counter antihistamines at least 24 hours before your appointment.
4. If you are taking a prescription antihistamine follow the table below.

| *ANTIHISTAMINE* | *STOP TAKING # OF DAYS PRIOR TO VISIT* |
|---|---|
| CLARITIN | 10 DAYS |
| ZYRTEC | 3-5 DAYS |
| ALLEGRA | 3-5 DAYS |

(*If you are uncertain about what antihistamine you are taking, call our office in advance.* ***DO NOT*** *Stop taking any Asthma Medications.)*

Our policy is to collect payment at the time of service, including all co-pay, deductibles and coinsurances. Attached you will find your benefits as quoted by your insurance company. If you are uncertain what your cost will be, please contact our office and/or your insurance company.

Failure to provide **all** of the required information listed above may result in rescheduling your appointment. Please complete the enclosed forms and bring them to your appointment.

In addition, we realize your time is valuable, please be prepared to be in our office for 2-2½ hours. We have reserved this time especially for you. If you need to reschedule or cancel your appointment, please call 24 hours in advance to cancel or reschedule your appointment at 254-753-3646, if you fail to call you will be charged a **$50.00 no show fee**.

Please feel free to call our office at (254) 753-3646 if you have any questions about your visit.

**PLEASE REMEMBER TO:**
**Bring your completed forms, insurance and referral with you.**

**WE LOOK FORWARD TO YOUR VISIT!**

# ALLERGY & ASTHMA CARE OF WACO

## Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

---

## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

☐ Home Telephone _____

☐ O.K. to leave a message with detailed information
☐ Leave message with callback number only

☐ Written communication

☐ O.K. to mail to my home address
☐ O.K. to mail to my work/office
☐ O.K. to fax to this number

☐ Work Telephone _____
☐ O.K. to leave a message with detailed information
☐ Leave a message with call-back number only

☐ Other (spouse, child, etc.) _____
_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate